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Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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1990 – AB 1521 (Margolin), Proposed
Conference Committee Report Pages 2-125

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PROPOSED CONFERENCE REPORT NO. 1
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CALIFORNIA LEGISLATURE—1989–90 REGULAR SESSION

ASSEMBLY BILL No. 1521

Introduced by Assembly Member Margolin

March 8, 1989

~~An act relating to insurance.~~ *An act to amend Sections 654.2, 2435, 2455, and 2499.5 of, and to add Sections 1001.5 and 2815.6 to, the Business and Professions Code, to amend Section 20036 of, to add Section 19867 to, and to add Article 8 (commencing with Section 21410) to Chapter 9 of Part 3 of Division 5 of Title 2 of, the Government Code, to amend Sections 439, 443.21, 443.26, 443.31, 443.33, 443.34, 443.35, 443.36, 443.37, and 1356 of, and to add Sections 443.315, 443.317, and 1343.05 to, the Health and Safety Code, to amend Sections 705, 11090, and 11509 of the Insurance Code, to add Part 8.5 (commencing with Section 2020) to Division 2 of the Labor Code, to amend Sections 17053.20 and 23615 of the Revenue and Taxation Code, and to add Sections 9390.6, 14017.7, and 14595 to, and to add Division 14 (commencing with Section 22000) to, the Welfare and Institutions Code, relating to health care, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1521, as amended, Margolin. Insurance: health ~~coverage study~~ *care coverage.*

~~Under existing law, the Insurance Commissioner is authorized to investigate various matters relating to insurance, and is required to make certain reports to the Legislature regarding the business of insurance.~~

~~This bill would require the commissioner to study the extent of private health insurance or health coverage purchased by employers, employees, and individuals, and report to the Legislature by July 1, 1991. The bill would require the study to be conducted within existing resources.~~

(1) Under existing law, basic health care services are provided to certain low-income individuals through the Medi-Cal program which is administered by the State Department of Health Services. However, there is no entity within state government that regulates the provision of health care insurance coverage or services to all citizens of the state, nor does existing law require employers to provide health care insurance coverage for their employees.

This bill would state the findings and declarations and intent of the Legislature regarding provision of health care services.

This bill would enact the Health Insurance Act of 1990 for the purpose of ensuring basic health care coverage for all persons in California. This bill would require all employers to provide minimum basic health care benefits, as defined, or to pay a premium for the provision of those benefits through the health coverage system established by this bill. This bill would provide for a credit against the required employer contribution for employers who certify under penalty of perjury that they provide their employees with specified minimum coverage.

By creating a new crime this bill would impose a state-mandated local program.

This bill would state the intent of the Legislature regarding future appropriations to fund this health care coverage system, and would create the California Health Plan Fund for the deposit of specified funds, including all the money in specified accounts of the Cigarette and Tobacco Products

urtax Fund, and money from the General Fund equivalent o the 1988–89 expenditures for the Medically Indigent ervices Program.

This bill would also provide for the collection of specified remiums and surcharges by the Franchise Tax Board or the mployment Development Department.

This bill would create the California Health Plan ommission as an independent authority to implement the rovisions of the bill. The commission would be divided into least 3 specified committees with enumerated duties.

The bill would impose underwriting standards on small oup carriers, as defined, or would allow these small group rriers to participate in the California Small Group einsurance Fund also created by this bill. The bill would also eate a large group purchasing pool for small businesses.

(2) Existing Personal Income Tax Law and Bank and rporation Tax Law authorize tax credits against the taxes posed by those laws for the provision of health coverage, as fined.

This bill would revise the amount of those credits and erative dates of those provisions.

(3) Under existing law, it is unlawful for certain licensed alth care providers to solicit payment from a patient or fer a patient to an organization in which that provider has beneficial interest unless the provider first discloses that neficial interest to the patient as well as to any carrier from ich the provider seeks payment.

This bill would revise these disclosure requirements.

(4) Existing law provides for fees to be paid by the plicants for certain professional licenses, and by licensees renewal of their professional license or certificate.

This bill would add additional fee requirements for various ensed or certified health care professionals in an amount to determined annually by the Director of the Office of tewide Health Planning and Development, not to exceed rtain limits, to be used to support specified health data llection activities.

(5) Under existing law, certain health facilities are quired to report specified data, and to pay fees for the eration of the California Health Policy and Data Advisory

Commission which collects that data.

This bill would add additional items to be reported, revise the advisory responsibilites of the commission, and revise the reporting provisions to incorporate reporting requirements for ambulatory surgery sites and carriers. This bill would further increase the fee to hospitals, but not to nursing homes, to cover the cost of the increased data collection on providers as reported by carriers. The bill would extend civil penalties to cover ambulatory surgery facilities and carriers, and would impose additional civil penalties of up to $5,000 or $10,000 for specified violations.

This bill would also impose an additional fee on health care service plans to pay for the cost of specified date collection responsibilities of the office.

(6) Existing law requires certain insurance carriers to pay fees for a certificate of authority to transact insurance business in this state.

This bill would also impose additional fees for specified data collection on these entities.

(7) Existing law requires the representatives of the Governor to meet and confer in good faith with representatives of recognized employee organizations regarding terms and conditions of state employment.

The bill would make legislative findings and declarations that the state's interests would be served by the Department of Personnel Administration meeting and conferring with state employee representatives, as specified, to discuss the establishment of long-term care benefits for state employees. It would provide that if long-term care insurance plans are not available to state employees on or before January 1, 1993, state employees may enroll in any long-term care insurance plans offered by the Board of Administration of the Public Employees' Retirement System. It would also provide that if the foregoing is in conflict with a memorandum of understanding, that the memorandum shall prevail and control without further legislative action, except that if the conflicting portions of the memorandum require the expenditure of funds, those provisions shall not become effective unless approved in the annual Budget Act.

The Public Employees' Retirement System, which is

stered by the Board of Administration, provides ient, insurance, and death benefits for state and local ment employees.

bill would require the board to contract with carriers g long-term care insurance plans and to enter into care service plan contracts covering long-term care make the plans available to members and annuitants Public Employee's Retirement System, their spouses, rents, as specified on or before January 1, 1992. The bill provide that the full costs of the plans shall be paid by rollees.

bill would appropriate from the Public Employees' ment Fund $125,000 to the board for developing in year 1990–91, those long-term care insurance plans and l require the board to submit a related report to the lature prior to implementing those plans.

Existing provisions of the Knox-Keene Health Care ce Plan Act of 1975 provides for the organization of us types of entities to provide health care coverage in n for a prepaid fee. Among those entities which are h care service plans, which are regulated by the missioner of Corporations, and nonprofit hospital service s, which are regulated by the Insurance Commissioner. is bill would exempt from the law applicable to health service plans those programs developed pursuant to ain federal statutes or the California Program of nclusive Care for the Elderly.

) Existing law requires the State Department of Health rices to implement a statewide program of nursing home admission screening.

his bill would require the department to implement an anded program of expanded nursing home preadmission eening and to require nursing facilities to document a admission screening, regardless of the source of the of ment for the person subject to the screening.

10) Existing law requires the department to issue a edi-Cal card to every person eligible for Medi-Cal benefits. This bill would, additionally, require the department to ovide each person who receives a Medi-Cal card and who aged, blind, or disabled, as defined, a prescribed written

notice concerning eligibility for in-home supportive services. It would also require the department to provide this notice to all state general acute care hospitals and long-term health care facilities, for distribution to each aged, blind, or disabled individual discharged from the hospital or facility into the community rather than an acute care hospital.

The bill would impose a state-mandated local program by requiring county welfare departments to provide any aged, blind, or disabled individual who is determined to be eligible for Medi-Cal benefits with a written notice informing him or her of eligibility for in-home supportive services, and to inform the recipient that application for in-home supportive services may be made at the county welfare department.

(11) Existing law authorizes the State Director of Health Services to establish the California Program of All-Inclusive Care for the Elderly, to promote the development of community-based, risk-based capitated, long-term care programs.

This bill would specify that during a period during which a risk-sharing contract under the California Program of All-Inclusive Care for the Elderly is in effect, eligible providers shall be exempt from the Knox-Keene Health Care Service Plan Act of 1975 regarding the services provided to Medi-Cal beneficiaries under the terms of the contract.

(12) Under existing law there are a number of programs which provide health care and social services to elderly persons. These programs are administered by various departments including the Department of Aging, the State Department of Health Services, and the State Department of Social Services.

This bill would create the California Partnership for Long-Term Care Pilot Program. The purpose of the pilot program would be to link private long-term care insurance, and health care service plan contracts which cover long-term care, with the in-home supportive services program and Medi-Cal, and to provide Medi-Cal benefits to certain individuals who have income and resources above the eligibility levels for receipt of medical assistance, but who have purchased certified private long-term care insurance policies and subsequently exhausted the benefits of these

private policies. The State Department of Health Services would be responsible for certifying those long-term care policies that meet enumerated criteria.

This bill would further specify that the program shall be designed so the estimated aggregate expenditures for long-term care services for individuals participating in the program do not exceed the estimated and aggregate expenditures that would be made for these services under the Medi-Cal program in effect prior to the implementation of this pilot program.

This bill would require the State Department of Health Services and the State Department of Social Services to exclude the amount of benefit payments made by certified long-term insurance policies and health care service plans, to the extent that the benefits paid are for specified services, when determining eligibility for Medi-Cal or in-home supportive services. The bill would require each department to adopt emergency regulations necessary for implementation of the program.

This bill would provide that individuals who participated in the pilot program shall remain eligible for the benefits provided for by the pilot program for the life of the purchaser, as long as the purchaser maintains his or her insurance policy or health care service plan contract in force.

This bill would provide that the State Department of Health Services is to serve as the lead agency. The department would be required to report to the Legislature annually on the progress of the program.

This bill would require specified counseling services to be provided to interested individuals. This bill would also create an advisory task force with specified members and duties.

This bill would require the State Department of Health Services to apply for a grant to pay for the administrative expenses of the program, and would make implementation of the program contingent on receipt of these private funds.

This bill would also authorize the State Department of Health Services to negotiate specified contracts with insurers and health care service plans on a nonbid basis, and would exempt these contracts from certain requirements of the Public Contract Code.

(13) The bill would further provide that this bill would not become operative unless a constitutional amendment exempting appropriations made from the Health Care Trust Fund from the appropriations limit set forth in Article XIII B of the California Constitution is enacted and approved by the voters, in which case some provisions would become operative on January 1, 1993, and others on January 1, 1995.

(14) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for specified reason.

Vote: majority. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. (a) The Insurance Commissioner shall study the extent of private health insurance or health coverage purchased by employers, employees, and individuals, and report to the Legislature on issues concerning individual and employer provided health insurance by July 1, 1991.~~

~~(b) The study shall be conducted within existing resources.~~

SECTION 1. The Legislature finds and declares all of the following:

(a) All Californians have a right to affordable, and reasonably priced health care and to nondiscriminatory treatment by health insurers and providers.

(b) While a significant majority of Californians receive health insurance through their employers as a result of employment, fewer employers in California provide this coverage than the nationwide average.

(c) In the last 10 years, the total number of uninsured persons in California has grown by 50 percent as a result of decreased employer coverage, more restrictive public program eligibility, and a system of competitive health care pricing.

(d) The uninsured population of California is over five million persons, and well over 80 percent of the uninsured are working persons and their family members, primarily working in small businesses, the service industry, agriculture, fishing, and other jobs where health insurance is not provided and at wages which make it impracticable to purchase private health insurance, and the number of persons with no health insurance continues to grow significantly.

(e) In addition, millions of Californians have inadequate health insurance which either does not protect them from the catastrophic health expenses accompanying serious illness, accident, or disabling condition, or does not ensure financial access to basic health services. Many Californians are denied health coverage because of preexisting conditions.

(f) This lack of basic minimum health insurance for the population is causing the following very serious problems:

(1) Low and decreasing access to inpatient care, prenatal care, emergency care, and outpatient care.

(2) A greater incidence of fair to poor health, disability, and restricted ability to perform daily activities, birth defects and lifelong disabilities, uncontrolled diabetes, hypertension, and untreated chronic conditions.

(3) Increasing financial problems among those providers which continue to treat a disproportionate share of persons without health coverage.

(4) Steadily increasing health insurance premiums for those decreasing numbers of payers who pay full charges for health services.

(5) Reliance on the government funded Medi-Cal and county health programs as catastrophic health insurer of last resort.

(g) The cost of health care has risen sharply in excess of all other components of the Consumer Price Index and at a rate higher than in any other industrialized country. The cost of health insurance has increased at a significantly greater rate than the costs of medical care.

(h) According to recent studies conducted by the University of California at Los Angeles and the Rand Corporation, the competitive pricing system in California has generated lower health care cost increases than in those states with traditional pricing mechanisms. However, competitive pricing has made it more difficult to pass on the cost of treatment for uninsured persons to payers for insured persons.

(i) To a large extent, those employers who provide health care for their employees are also absorbing the costs of the uninsured. If economic competition is to be fair and equitable, all employers should absorb these costs equally.

(j) Small businesses employing low-wage workers, and self-employed persons experience severe financial disincentives to purchasing health insurance since the premiums for these plans are as much as 30 to 50 percent higher than premiums for health policies sold to large groups.

(k) Over 90 percent of California's population live in a county which provides and coordinates a health care safety net system for residents who are indigent or who are uninsured and cannot afford to pay for the cost of medical care. The benefits of that system include:

(1) Linkage of medical care for the poor with public health, mental health, and other social services.

(2) Cost-effective, publicly accountable expenditure of public funds.

(3) Provision of services based on the health care needs of the population rather than market or private profit calculations.

Severe underfunding of the health care safety net in California in recent years has impeded full compliance with statutory mandates. A strong, economically viable public health care delivery system capable of providing care fully equal to community standards is a necessary goal of the universal health care system created by this act.

(l) Uniform employer coverage would substantially reduce the number of Californians without health

insurance.

(m) California is facing dramatic increases in the demand for long-term care due to the aging of the population, medical technology, increasing numbers of children born with disabilities and growing numbers of persons with AIDS, Alzheimer's, and other debilitating conditions.

(n) The over 65 age group is the fastest growing population in the state, with the over 85 population expected to grow three times faster than the under age 65 population over the next 30 years. Yet, at least 35 percent of the persons needing long-term care services are under 65.

(o) The current long-term care services delivery network in the state is seriously fragmented and denies access to long-term care services to hundreds of thousands of persons with disabilities who need such services.

(p) The state lacks an integrated system to provide a continuum of social and health support services, including institutional, in-home and community-based services to meet the needs of California's growing population of older persons and persons with disabilities.

(q) It is the intent of the Legislature to seek solutions to respond to unmet long-term care needs in a manner which integrates long term care services with basic health care.

SEC. 2. It is the intent of the Legislature to:

(a) Build on existing health insurance and health care service delivery systems, and preserve and expand the capacity of the existing public and private delivery systems.

(b) Provide incentives for the health care system to provide expanded, affordable coverage through the expansion of managed care systems.

(c) Provide for a series of evolutionary steps to modify the current system of private insurance and provider rate setting if goals regarding access and price stability are not met within a reasonable time frame.

(d) Maximize federal participation in health care

funding.

(e) Provide a minimum health care benefit package to all Californians, including those that are currently uninsured.

(f) Identify an affordable, medically viable, and actuarially sound package of minimum benefits, or a minimum benefits package defined by a cost limit.

(g) Be fair to businesses by:

(1) Assuring that businesses have a primary fiscal and managerial role in providing health coverage for employees.

(2) Assuring that coverage is affordable and available to all businesses.

(h) Avoid nonproductive employment incentives, enable employers to make employment and personnel decisions based on productivity rather than on avoiding the costs of health care coverage, and retain current flexibility in benefits for both employers and employees.

(i) Provide coverage to dependents of employees, as well as employees, in a cost-effective manner through the economies of scale associated with large risk pools and reduced per capita costs for dependent coverage.

(j) Control future year costs in order to prevent unwarranted future cost increases, and accentuate positive cost containment incentives.

(k) Take into consideration the ability of low-income employees to share the burden of health care coverage.

(l) Take into consideration the resources available to businesses, particularly small businesses, for their share of the burden.

(m) Prudently allocate and reallocate resources within the health care insurance and delivery systems.

(n) Combine cost containment, systems reform, and resource allocation to provide for the structural and fiscal integrity of the health care system.

(o) Maintain and improve California's public health care delivery system so that it is capable of providing care fully equal to community standards.

(p) Hold the increases in individual and group health insurance and health care coverage to a target agreed

upon by the purchasers, providers, and consumers of basic health services.

(q) Protect the public from unfair pricing and substandard quality in the coverage of health care costs by health insurers and in the delivery of health care services by health care providers.

(r) Implement all the necessary changes in the health care system in a cost-effective and administratively streamlined fashion.

SEC. 3. It is the further intent of the Legislature that:

(a) The insurance reforms contained in the act which enacted this section guarantee availability, renewability and premium stability for basic health coverage to small employers and their employees.

(b) The purchasing reforms contained in the act which enacted this section enable small employers to negotiate collectively for the most favorable rates of health coverage feasible.

(c) The cost containment reforms improve information to and bargaining power of, purchasers of health care to allow a competitive market to function effectively. The reforms are designed to remove incentives for excessive billings, unnecessary treatment, and administrative waste which persists in the current system. The reforms are designed to assure that insurers compete on the basis of price and ability to control health care costs and not on the basis of marketing strategies designed to exclude high-risk individuals or groups of uninsured persons. It is the intent of the legislation which enacted this section to hold the premium increases for a basic package of health services to a targeted level and to have a fall-back fail-safe system of guarantees to individuals and employers obliged to purchase health care of the long-term affordability of basic coverage.

(d) The act which enacted this section will provide a cap on the spiraling percentages of small business payroll devoted to health premiums and to provide special subsidies for new small employers and small low-wage employers who cannot afford the fall costs of a basic health plan. It is also the intent of this legislation to

promote job creation and minimum basic health coverage among small employers.

SEC. 4. Section 654.2 of the Business and Professions Code is amended to read:

654.2. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which the licensee, or the licensee's immediate family, has a significant beneficial interest, unless the licensee first discloses in writing to the patient, that there is such an interest and advises the patient that the patient may choose any organization for the purpose of obtaining the services ordered or requested by the licensee.

(b) The disclosure requirements of subdivision (a) may be met by posting a conspicuous sign in an area which is likely to be seen by all patients who use the facility or by providing those patients with a written disclosure statement. Where referrals, billings, or other solicitations are between licensees who contract with multispecialty clinics pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of subdivision (a) may be met by posting a conspicuous disclosure statement at a single location which is a common area or registration area or by providing those patients with a written disclosure statement.

(c) ~~On and after July 1, 1987, persons licensed under this division or under any initiative act referred to in this division shall disclose in writing to any third/party payer for the patient, when requested by the payer, organizations in which the licensee, or any member of the licensee's immediate family, has a significant beneficial interest and to which patients are referred. The third/party payer shall not request this information~~

~~from the provider more than once a year.~~

~~Nothing in this section shall be construed to serve as the sole basis for the denial or delay of payment of claims by third party payers~~ *Any person licensed under this division or under any initiative act referred to in this division shall also disclose any organizations in which the licensee has any significant beneficial interest to any carrier from whom the person is seeking payment or reimbursement.*

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Immediate family" includes the spouse and children of the licensee, the parents of the licensee and licensee's spouse, and the spouses of the children of the licensee.

(2) "Significant beneficial interest" means any financial interest that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

(B) Five thousand dollars ($5,000).

(3) A third-party payer includes any health care service plan, self-insured employee welfare benefit plan, disability insurer, nonprofit hospital service plan, or private group or indemnification insurance program.

A third party payer does not include a prepaid capitated plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 or Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(e) This section shall not apply to a "significant beneficial interest" which is limited to ownership of a building where the space is leased to the organization at the prevailing rate under a straight lease agreement or to any interest held in publicly traded stocks.

(f) (1) This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, if the report indicates clearly the name of the laboratory performing the test.

(2) This section shall not apply to relationships governed by other provisions of this article nor is this section to be construed as permitting relationships or interests that are prohibited by existing law on the effective date of this section.

(3) The disclosure requirements of this section shall not be required to be given to any patient, customer, or his or her representative, if the licensee, organization, or entity is providing or arranging for health care services pursuant to a prepaid capitated contract with the State Department of Health Services.

SEC. 5. Section 1001.5 is added to the Business and Professions Code, to read:

1001.5. Fees payable by applicants for a license and by licensees for renewal of a license shall be increased by an amount not to exceed fifty dollars ($50) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the board the amount to be assessed. Moneys collected pursuant to this section shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code. No initial or renewal license shall be issued unless the fees required by this section are paid.

SEC. 6. Section 2435 of the Business and Professions Code is amended to read:

2435. The following fees apply to physician's and surgeon's certificates, certificates of drugless practitioners, and certificates to practice midwifery:

(a) Each applicant for a certificate based upon a national board diplomate certificate, and each applicant for a certificate based on reciprocity, and each applicant for a certificate based upon written examination, shall pay a nonrefundable application and processing fee, as set forth in subdivision (b), at the time the application is filed.

(b) Between January 1, 1987, and December 31, 1989, the application and processing fee, for the first year, shall be two hundred seventy-five dollars ($275), and, for each

subsequent year, shall be equal to the prior year's fee plus a sum fixed by the Division of Licensing equal to not more than 10 percent of the prior year's fee, up to a maximum of three hundred fifty dollars ($350). On and after January 1, 1990, the application and processing fee shall be fixed by the Division of Licensing by May 1 of each year, to become effective on July 1 of that year. The fee shall be fixed at an amount necessary to recover the actual costs of the licensing program as projected for the fiscal year commencing on the date the fees become effective.

(c) Each applicant for a certificate by written examination, unless otherwise provided by this chapter, shall pay an examination fee fixed by the board, which shall equal the actual cost to the board of the purchase of the written examination furnished by the organization pursuant to Section 2176, plus the actual cost to the board of administering the written examination. Such actual cost to the board of administering the written examination that shall be charged to the applicant shall not exceed one hundred dollars ($100). The board may charge the examination fee provided for in this section for any subsequent reexamination of the applicant.

(d) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required herein, shall pay an initial license fee, if any. On and after July 1, 1987, the initial license fee shall be fixed by the board at an amount not less than two hundred ninety dollars ($290), and not to exceed four hundred dollars ($400), in accordance with paragraph (2) of subdivision (e). Any applicant enrolled in an approved postgraduate training program shall be required to pay only 50 percent of the initial license fee.

(e) (1) The biennial renewal fee shall be fixed by the board at an amount not less than two hundred ninety dollars ($290), and not to exceed four hundred dollars ($400), in accordance with paragraph (2).

(2) The board shall fix the biennial renewal fee and the initial license fee so that, together with the amounts from other revenues, the reserve balance in the board's

contingent fund shall be equal to approximately four months of annual authorized expenditures. Any change in the renewal and initial license fees shall be effective upon a determination by the board, by emergency regulations adopted pursuant to Section 2436, that changes in the amounts are necessary to maintain a reserve balance in the board's contingent fund equal to four months of annual authorized expenditures in the state fiscal year in which the expenditures are to occur.

(f) Notwithstanding Section 163.5, the delinquency fee is 10 percent of the biennial renewal fee.

(g) The duplicate certificate and endorsement fees shall each be fifty dollars ($50), and the certification and letter of good standing fees shall each be ten dollars ($10).

(h) It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Board of Medical Quality Assurance equal to approximately four months' operating expenditures.

(i) In addition to any fees specified above, the board, effective July 1, 1993, shall assess each applicant for an initial license, or for renewal, an amount not to exceed one hundred dollars ($100) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the board the amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code. No initial or renewal license shall be issued unless the fees required by this subdivision are paid.

SEC. 7. Section 2455 of the Business and Professions Code is amended to read:

2455. The amount of fees and refunds is that fixed by the following schedule for any certificate issued by the Board of Osteopathic Examiners. All other fees and refunds for any certificate issued by the Board of Osteopathic Examiners and which are not prescribed in

this schedule, are prescribed in Section 2456.

(a) Each applicant for an original or reciprocity Physicians and Surgeons Certificate shall pay an application fee in a sum not to exceed two hundred dollars ($200) at the time his or her application is filed. If the applicant's credentials are insufficient, or if he or she does not take the examination, the board may retain a sum equal to the actual cost of processing the application, not to exceed one hundred fifty dollars ($150) and the remainder of the fee is returnable upon application.

(b) The oral and practical examination fee shall not exceed two hundred dollars ($200) nor be less than fifty dollars ($50).

(c) The annual tax and registration fee, unless otherwise provided, shall be set by the board on or before November 1 of each year for the ensuing calendar year at a sum as the board determines necessary to defray the expenses of administering this chapter, under the Osteopathic Act, relating to the issuance of certificates to those applicants, which sum, however, shall, not exceed two hundred dollars ($200) nor be less than twenty-five dollars ($25).

(d) The board shall set an annual tax and registration fee in an amount less than that levied pursuant to subdivision (c) which shall be paid by any applicant who indicates to the board in writing that he or she does not intend to practice under the Osteopathic Act during the renewal period covered by that annual tax and registration fee.

(e) The fee for failure to pay the annual tax and registration fee shall be 50 percent of the renewal fee but not more than one hundred dollars ($100).

(f) In addition to any fees specified above, the board, effective July 1, 1993, shall assess each applicant for an initial certificate, or for renewal, an amount not to exceed fifty dollars ($50) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the board the

amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code. No initial or renewal certificate shall be issued unless the fees required by this subdivision are paid.

SEC. 8. Section 2499.5 of the Business and Professions Code is amended to read:

2499.5. The following fees apply to certificates to practice podiatric medicine. The amount of fees prescribed for doctors of podiatric medicine shall be those set forth in this section unless a lower fee is fixed by the board in accordance with Section 2499.6. Fees collected pursuant to this section shall be fixed by the board in amounts not to exceed the actual costs of providing the service for which the fee is collected.

(a) Each applicant for a certificate by written examination, unless otherwise provided by this chapter, shall pay an application fee fixed by the board at an amount of one hundred fifty dollars ($150).

(b) Each applicant for a certificate based upon a national board examination, and each applicant for a certificate based upon reciprocity shall pay an application fee of twenty dollars ($20) at the time the application is filed. If the applicant qualifies for a certificate, he or she shall pay a fee which shall be fixed by the board at an amount not to exceed one hundred dollars ($100) nor less than five dollars ($5) for the issuance of the certificate.

(c) The oral examination fee shall be seven hundred dollars ($700), or the actual cost, whichever is lower, and shall be paid by each applicant. If the applicant's credentials are insufficient or if the applicant does not desire to take the examination, and has so notified the board 30 days prior to the examination date, only the examination fee is returnable to the applicant. The board may charge an examination fee for any subsequent reexamination of the applicant.

(d) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required herein, shall pay an initial license fee. The

initial license fee shall be eight hundred dollars ($800). If the license will expire less than one year after its issuance, then the initial license fee is an amount equal to 50 percent of the initial license fee fixed by the board. The board may waive or refund the initial license fee where the license will expire within 45 days after it is issued.

(e) The biennial renewal fee shall be eight hundred dollars ($800). Any licensee enrolled in an approved residency program shall be required to pay only 50 percent of the biennial renewal fee at the time of his or her first renewal.

(f) The delinquency fee is one hundred fifty dollars ($150).

(g) The duplicate wall certificate fee is forty dollars ($40).

(h) The duplicate renewal receipt fee is forty dollars ($40).

(i) The endorsement fee is thirty dollars ($30).

(j) The letter of good standing fee or for loan deferment is thirty dollars ($30).

(k) There shall be a fee of sixty dollars ($60) for the issuance of a limited license under Section 2475.

(*l*) The application fee for certification under Section 2473 shall be fifty dollars ($50). The examination and reexamination fee for this certification shall be seven hundred dollars ($700).

(m) The filing fee to appeal the failure of an oral examination shall be twenty-five dollars ($25).

(n) The fee for approval of a continuing education course or program shall be one hundred dollars ($100).

(o) In addition to any fees specified above, the board, effective July 1, 1993, shall assess each applicant for an initial certificate, or for renewal, an amount not to exceed one hundred dollars ($100) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the board the amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created

pursuant to Section 439 of the Health and Safety Code. No initial or renewal certificate shall be issued unless the fees required by this subdivision are paid.

SEC. 9. Section 2815.6 is added to the Business and Professions Code, to read:

2815.6. In addition to any fees specified above, the board, effective July 1, 1993, shall assess each applicant for an initial certificate as a nurse midwife, nurse anesthetist, or nurse practitioner, or for renewal, an amount not to exceed fifty dollars ($50) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the board the amount to be assessed. Moneys collected pursuant to this section shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code. No initial or renewal certificate shall be issued unless the fees required by this section are paid.

SEC. 9.2. Section 19867 is added to the Government Code, to read:

19867. (a) The Legislature finds and declares that the interests of the state would be served by the Department of Personnel Administration meeting and conferring with the exclusive representatives of the various bargaining units to discuss the establishment of long-term care benefits for state employees.

(b) If long-term care insurance plans are not available to state employees on or before January 1, 1993, state employees may enroll in any long-term care insurance plans offered by the Board of Administration of the Public Employees' Retirement System.

(c) If this section is in conflict with a memorandum of understanding entered into pursuant to Section 3517.5, the memorandum of understanding shall prevail and control without further legislative action, except that if the prevailing provisions of a memorandum of understanding require the expenditure of funds, these provisions shall not become effective unless approved by the Legislature in the annual Budget Act.

SEC. 9.4. Section 20036 of the Government Code is amended to read:

20036. "Benefit" means the retirement allowance, basic death benefit, limited death benefit, special death benefit, any monthly allowance for survivors of a member or retired person, the insurance benefit ~~or~~, *the* refund of accumulated contributions, *or the study of long-term care insurance and health care service plan contracts covering long-term care.*

SEC. 9.6. Article 8 (commencing with Section 21410) is added to Chapter 9 of Part 3 of Division 5 of Title 2 of the Government Code, to read:

Article 8. Long-Term Care

21410. This article may be cited as the Public Employees' Long-Term Care Act.

21411. (a) The board shall contract with carriers offering long-term care insurance plans and enter into health care service plan contracts covering long-term care.

The long-term care insurance plans and health care service plan contracts covering long-term care shall be made available on or before January 1, 1992, and periodically thereafter during open enrollment periods determined by the board.

(b) The board shall award contracts to carriers who are qualified to provide long-term care benefits, and may develop and administer self-funded long-term care insurance plans. The board may offer one or more long-term care insurance plans or health care service plan contracts covering long-term care and may offer service or indemnity-type plans.

(c) The long-term care insurance plans and health care service plan contracts covering long-term care shall include home, community, and institutional care and shall, to the extent determined by the board, provide substantially equivalent coverage to that required under Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code, if the carrier has

been approved by the Department of Corporations pursuant to the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) Members and annuitants of the Public Employees' Retirement System, and their spouses and parents, shall be eligible to enroll provided they meet the eligibility and underwriting criteria established by the board, except that enrollment of state employees shall be subject to Section 19867.

(e) The board shall establish eligibility criteria for enrollment, establish appropriate underwriting criteria for potential enrollees, define the scope of covered benefits, define the criteria to receive benefits, and set any other standards as needed.

(f) The full cost of enrollment in a long-term care insurance plan or in health care service plan contracts covering long-term care shall be paid by the enrollees.

21412. The board shall consult with employer and employee representatives of the state and local government entities for whom the board administers retirement benefits. The board and each employer is authorized to recover the administrative costs of the long-term care insurance program from insurance carriers and premiums paid by enrollees. Prior to implementation of the proposed long-term care insurance plans, the board shall submit a report on those plans to the Legislature.

21413. (a) (1) There is hereby appropriated from the Public Employees' Retirement Fund, the sum of one hundred twenty-five thousand dollars ($125,000) to the Board of Administration of the Public Employees' Retirement System for expenditure in the 1990–91 fiscal year for developing long-term care insurance plans and health care service plan contracts covering long-term care for participants in the system.

(2) In developing the long-term care program, the board shall also determine whether expanding the participation in the plans would benefit members and annuitants by reducing premiums and creating a viable

risk pool.

(b) The board shall include in the costs of enrollment a reasonable amount to recover and reimburse the fund for the amount appropriated by this section.

SEC. 10. Section 439 of the Health and Safety Code is amended to read:

439. (a) ~~Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall be charged a fee of not more than 0.035 percent of the health facility's gross operating cost for the provision of health care services for its last fiscal year ending prior to the effective date of this section. Thereafter~~ *Each year* the office shall set for, charge to, and collect from all health facilities, *licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 as of July 1 of that year,* except health facilities owned and operated by the state, a special fee, which shall be due on July 1, and delinquent on July 31 of each year ~~beginning with the year 1977~~, of not more than 0.035 percent of the health facility's gross operating cost for provision of health care services for its last fiscal year which ended on or before June 30 of the preceding calendar year. Each year the office shall establish the fee to produce revenues equal to the appropriation to pay for the functions required to be performed pursuant to this part, Part 1.75 (commencing with Section 442), or Part 1.8 (commencing with Section 443) by the office, the area and local health planning agencies, and the ~~Advisory Health Council~~ *California Health Policy and Data Advisory Commission.*

(1) The office, within the 0.035 limit imposed by this subdivision, shall increase the fee for hospitals without increasing the fee for nursing homes so as to cover the office's costs resulting from reporting of data as required by Section 443.315 from hospital owned or operated ambulatory surgical facilities.

(2) Each year, the office shall set for, charge to, and collect from all ambulatory surgery sites defined in paragraph (2) or (3) of subdivision (b) of Section 443.21, a special fee of not more than 0.15 percent of the site's

gross operating cost for the provision of health care services for its last fiscal year ending on or before June 30 of the preceding calendar year. The fee shall be due on July 1 and delinquent on July 31 of each year. The fee shall be established to cover the costs to the office resulting from the reporting of data as required by Section 443.315 by those sites.

Health facilities which pay fees shall not be required to pay, directly or indirectly, the share of the costs of those health facilities for which fees are waived.

(b) There is hereby established the California Health Data and Planning Fund within the Office of Statewide Health Planning and Development for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(c) Any amounts raised by the collection of the special fees provided for by subdivision (a) of this section which are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the council in succeeding years when appropriated by the Legislature, for expenditure under the provisions of this part, Part 1.75 (commencing with Section 442), and Part 1.8 (commencing with Section 443) and shall reduce the amount of the special fees which the office is authorized to establish and charge.

(d) No health facility *or nonhospital ambulatory surgery site* liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. New, previously unlicensed health facilities *or nonhospital ambulatory surgery sites* shall be charged a pro rata fee to be established by the office during the first year of operation.

The license of any health facility *or nonhospital ambulatory surgery site*, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by

subdivision (a).

SEC. 11. Section 443.21 of the Health and Safety Code is amended to read:

443.21. As used in this part, the following terms mean:

(a) *"Ambulatory surgery" means those surgical procedures, or procedures performed as a substitute for surgery, which are performed on an outpatient basis.*

(b) "Ambulatory surgery site" means any of the following:

(1) Ambulatory surgical facilities operated under auspices of hospital licensure.

(2) Surgical clinics licensed under paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code.

(3) Medicare-certified ambulatory surgery facilities.

(c) "Carrier" means any insurer (including, but not limited to, insurance companies, nonprofit hospital service plans, fraternal benefit societies, and firemen's, policemen's or peace officers' benefit and relief associations), health care service plan other than a Specialized Health Care Service Plan, self-funded employer sponsored plan, multiple employer trust, or Taft-Hartley Trust as defined by federal law, authorized to pay for health care services in this state. "Carrier" includes the State Compensation Insurance Fund and PERS Care.

(d) "Commission" means the California Health Policy and Data Advisory Commission.

~~(b)~~

(e) "Criterion for basic service" means a ranking of cost-effective surgical, medical, and preventative health care procedures or courses of treatment appropriate to major demographically defined groups.

(f) "Director" means the Director of the Office of Statewide Health Planning and Development.

(g) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, *except correctional treatment centers.*

~~(c)~~

(h) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

~~(d)~~

(i) "Office" means the Office of Statewide Health Planning and Development.

(j) "Professional health care services" means any diagnostic or treatment services provided in California directly to a patient by a person licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code to practice medicine, osteopathy, chiropractic, or podiatry, or by a person licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code as a nurse midwife, nurse practitioner, or nurse anesthetist, who is not an employee.

(k) "Service effectiveness" means the effectiveness of services rendered by a hospital provider, determined by measurement of the clinical outcomes of patients at a standardized point during the patient stay, and grouped by admission severity and complexity.

(l) "Service efficiency" means the efficiency of services rendered by a hospital provider as measured by comparing patient actual resource utilization to expected resource need which is based on admission severity and complexity and adjusts for service effectiveness.

(m) "Service quality" means the extent to which a hospital provider renders care that, within the capabilities of modern medicine, obtains for patients medically acceptable clinical outcomes measured at a standardized point during the patient stay, and adjusted for patient admission severity and complexity.

SEC. 12. Section 443.26 of the Health and Safety Code is amended to read:

443.26. The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data.

(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

(e) Conduct public meetings for the purposes of obtaining input from health facilities, data users, and the general public regarding this part and Part 1.5 (commencing with Section 437).

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.

(h) Advise the office on the format of individual health facility reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Part 1.5 (commencing with Section 437).

(j) Advise the office on the implementation of Sections 443.315 and 443.317 with respect to the identification of ambulatory surgeries and professional health care services required to be reported pursuant to those sections.

(k) Recommend to the office, in consultation with a nine-member technical advisory committee appointed by the chairperson of the commission, all of the following:

(1) An appropriate methodology for use by hospitals which permits both of the following:

(A) Admission severity and complexity coding.

(B) Measurement of the clinical outcomes at a standardized post treatment interval during the patient stay, for all discharges reported on the hospital discharge abstract data record required by subdivision (g) of

Section 443.31.

(2) A cost-effective ranking of surgical, medical, and preventative health care procedures or courses of treatment which constitute a criterion for basic service financed by public or private third-party purchasers of care.

(l) (1) The technical advisory committee shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by an association representing general acute care hospitals, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, one member who shall be a representative of a health facility described in subdivision (d) of Section 443.34, two members who shall be representatives of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, one member representing the Consumers Union, and one member who shall be a registered nurse appointed from a list of at least three persons nominated by the California Nurses' Association.

(2) Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.

(m) The commission shall submit the recommendations on the subjects specified in paragraph (1) of subdivision (k) no later than June 1, 1993. The commission shall submit its recommendation to the office on the subject specified in paragraph (2) of subdivision (k) no later than June 30, 1994, and shall update its recommendation thereon on an annual basis.

(n) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of

the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.

The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

SEC. 13. Section 443.31 of the Health and Safety Code is amended to read:

443.31. Every organization which operates, conducts, or maintains a health facility and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office which shall be in accord where applicable with the systems of accounting and uniform reporting required by this part, except the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 443.34 are not required to report revenue by revenue center.

(d) A statement detailing changes in financial position

and capital financing status, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 443.34.

(f) The office shall consult with the County Hospital Committee of the California Hospital Association, the County Supervisors Association of California, and the California Association of Public Hospitals to improve the accuracy of indigent care revenue reporting and shall present legislative or regulatory recommendations for such improvements by March 30, 1985.

(g) A Hospital Discharge Abstract Data Record which includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race *and ethnicity*.

(4) Zip code *of patient's primary residence*.

(5) Patient social security number, if it is contained in the patient's medical record.

(6) Admission date.

(7) Source of admission.

(8) Type of admission.

(9) Discharge date.

(10) Principal diagnosis.

(11) Other diagnoses.

(12) External cause of injury, *if applicable*.

(13) Principal procedure ~~and~~, date, *and license number of the principal health care professional performing the procedure*.

(14) Other procedures, ~~and~~ dates, *and license number of the principal health care professional performing each procedure*.

(15) Total charges, *daily hospital charges, and ancillary charges*.

(16) Disposition of patient.

(17) Expected source of payment.

(18) Type of coverage (such as indemnity, prepaid, preferred provider, etc.).

(19) License number of the attending health care professional.

(20) Service effectiveness and service quality of care indicators which include measures of admission severity and complexity and clinical outcomes measured at a standardized point during the patient stay.

(21) Type of care indicator.

A hospital owned or operated by a county or city and county shall not be required to provide the information listed in paragraph (20) or (21).

The office with the advice of the commission, shall develop, adopt, and require the use of a methodology by hospitals for the purpose of entering service effectiveness and service quality of care indicators in the hospital discharge abstract data record which includes measures of admission severity and complexity, and of clinical outcomes measured at a standardized point during the patient stay.

It is the intent of the Legislature that the standardized measures of service effectiveness and service quality shall be included in reports published by the office in a format that will show useful comparisons and analyses of hospital performance including service efficiency.

In the event the office is unable to develop and adopt a methodology and data set for use by hospitals as required by this section by July 1, 1993, the office shall adopt and require all hospitals to use a methodology available in the public or private domain which enables the reporting of measures of admission severity and complexity and of clinical outcomes.

It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1

of the Government Code).

No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data which has been mailed or otherwise transmitted to the office pursuant to the requirements of this subdivision.

A hospital or its designee shall semiannually file the Hospital Discharge Abstract Data Record not later than six months after the end of each semiannual period, commencing six months after January 1, 1986. A hospital may submit the Hospital Discharge Abstract Data Record in a computer tape format, and a hospital shall use coding from the International Classification of Diseases, *9th Revision Clincal Modification,* in reporting diagnoses and procedures.

(h) The director, in consultation with the commission, shall specify a comparable data requirement to the data under paragraph (15) of subdivision (g) for providers which receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans.

SEC. 14. Section 443.315 is added to the Health and Safety Code, to read:

443.315. (a) Each ambulatory surgery site shall file a semi-annual report on ambulatory surgeries including an Ambulatory Surgery Record for each instance in which a reportable ambulatory surgery was performed.

(b) The reports required by subdivision (a) shall be filed in an electronic format specified by the office. An ambulatory surgery site reporting fewer than 100 records may elect to submit the data on a reporting form specified by the office. Each Ambulatory Surgery Record shall include the following:

(1) Date of birth.

(2) Sex.

(3) Race and ethnicity.

(4) Zip code of patient's primary residence.

(5) Patient social security number, if it is contained in the patient's record.

(6) Date of service.

(7) Principal diagnosis.

(8) Other diagnosis.

(9) External cause of injury, if applicable.

(10) Principal procedure and license number of the principal health care professional performing the procedure.

(11) Other procedures and license number of the principal health care professional performing each procedure.

(12) Disposition of patient.

(13) Total charges and ancillary charges.

(14) Expected source of payment.

(15) Type of coverage (such as indemnity, prepaid, preferred provider, etc.).

(c) The director, in consultation with the commission, shall specify a comparable data requirement to the data under paragraph (13) of subdivision (b) for providers which receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans.

(d) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

No person reporting data pursuant to this section shall be held liable for damages in any action based on use or misuse of patient-identifiable data which has been mailed or otherwise transmitted to the office pursuant to the requirements of this section.

(e) The office shall specify ambulatory surgeries to be reported. Ambulatory surgeries of significant interest with respect to cost containment, utilization monitoring, or related issues, as determined by the office, shall be required to be reported.

(f) Each nonhospital ambulatory surgery site shall file

a report consisting of audited financial statements for the site with the office on or before March 31 of each year for the fiscal period which ended in the previous calendar year.

SEC. 15. Section 443.317 is added to the Health and Safety Code, to read:

443.317. (a) Each carrier shall file a quarterly report on professional health care services including a professional health care services record for each instance in which it provides coverage for professional health care services specified by the office pursuant to subdivision (f). The report on professional health care services for services for which coverage is established in each calendar quarter shall be due within 90 days of the end of the quarter.

(b) The reports required by subdivision (a) shall be filed in an electronic format specified by the office. Each professional health care services record shall include at least the following:

(1) Date of birth.

(2) Sex.

(3) Race and ethnicity.

(4) Zip code of patient's primary residence.

(5) Patient social security number.

(6) Diagnoses.

(7) External cause of injury, if applicable.

(8) Procedures, date each was performed, and license number of principal health care professional performing each procedure.

(9) Zip code in which procedures were performed.

(10) Place of service (such as hospital in-patient, hospital out-patient, hospital emergency room, ambulatory surgery center, urgent care center, clinic, office, etc.).

(11) Total charges, and charge for each procedure, if coverage is provided on a fee-for-service basis.

(12) Carrier identification code.

(13) Type of coverage (such as indemnity, prepaid, preferred provider, etc.).

(c) The director, in consultation with the commission,

shall specify a comparable data requirement to the data under paragraph (11) of subdivision (b) for providers which receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans.

(d) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data which has been mailed or otherwise transmitted to the office pursuant to the requirements of this section.

(e) The office shall develop a California Uniform Claim Form format. Carriers shall require a completed California Uniform Claim Form, or the electronic equivalent, for each instance in which they provide coverage on a fee-for-service basis for professional health care services. The State Department of Health Services shall adopt the California Uniform Claim Form format for use in all health care payment programs it administers (including Medi-Cal, county health service programs, and other health care payment programs) which provide coverage for professional health care services on a fee-for-service basis.

(f) The office shall specify professional health care services to be reported. Services of significant interest with respect to cost containment, utilization monitoring, or related issues, as determined by the office, shall be required to be reported.

(g) The office, with the advice of the California Health Policy and Data Advisory Commission, shall adopt procedures for analyzing reports submitted pursuant to this section for data accuracy and shall establish

acceptable error rates. An error analysis shall be prepared for each quarterly report on Professional Health Care Services filed with the office. The analysis shall be available whenever the report is available, and a copy shall be provided to the carrier which filed the report. If an analysis determines that the error rate exceeds the acceptable error rate, the carrier will be specifically notified of that fact and notified that future reports must meet accuracy standards. If, following submission of its first four reports, a carrier files three sequential reports or a total of four reports for quarters occurring within any 24-month period that have an unacceptable error rate, the carrier will be subject to civil penalties as specified in Section 443.36.

(h) The State Department of Health Services shall provide the office with a Professional Health Care Services Record as specified in subdivision (b) for each instance in which it provides coverage for professional health care services specified by the office pursuant to subdivision (f) through programs it administers, including Medi-cal, county health service programs, and other health care payment programs. Instead of a carrier identification code, the State Department of Health Services shall report a program identification code. Data shall be reported to the office for services for which coverage is established within each calendar quarter within 90 days of the end of the quarter, or within such other time frame as the office establishes.

(i) The Department of Corporations shall forward to the office at least annually, or more frequently upon request, a list of all health care services plans licensed under Section 1353 which are required to provide the basic health care services defined in subdivision (b) of Section 1345. The Department of Insurance shall forward to the office at least annually, or more frequently upon request, a list of all insurers authorized to transact disability insurance in this state, all fraternal benefit societies holding the certificate of authority required by Section 11014 of the Insurance Code, all firemen's, policemen's, or peace officers' benefit and relief

associations holding the certificate of authority required by Section 11401 of the Insurance Code, and all nonprofit hospital service plan corporations holding the certificate of authority required by Section 11504 of the Insurance Code.

(j) The office shall, to the extent feasible, obtain data on Medicare payment of claims for professional health care services in order to supplement the data base created by this section. The office shall seek data comparable to that included in Professional Health Care Services Records.

(k) At any time that the office is legally prohibited from requiring the submission by self-funded employer sponsored plans of the data described in this section, all data submission requirements described in this section shall be suspended as long as the legal prohibition remains in effect.

SEC. 16. Section 443.33 of the Health and Safety Code is amended to read:

443.33. (a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 443.31 with the office within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The office shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b) (1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, and congregate living facilities, including nursing facilities certified by the state department to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 443.31 with the office within four months after the close of the facility's fiscal year, except as provided in paragraph (2).

(2) (A) If a licensee relinquishes the facility license or

puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 443.31 within two months after the last day of active licensure.

(3) The office shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4) (A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 443.31 shall be filed with the office by electronic media, as determined by the office.

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) The reports required by subdivision (g) of Section 443.31 shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period, commencing six months after January 1, 1986, and shall be available from the office no later than six months after the date upon which the report was filed.

(d) The reports referred to in paragraph (2) of subdivision (a) of Section 443.30 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date upon which the report was filed.

(e) *The reports required by Section 443.315 shall be filed semiannually by each ambulatory surgery site or its designee not later than six months after the end of each semiannual period, and shall be available from the office no later than six months after the date upon which the report was filed.*

(f) The office shall make available ~~at cost,~~ to all interested parties, a hard copy of any health facility report referred to in subdivision (a), (b), (c), *or* (d) ~~; or (g)~~ of Section 443.31 ~~and in~~ *or a summary of any report referred to in subdivision (g) of Section 443.31, in Section*

443.315, or Section 443.317. In addition to hard copies, *the office* shall make available ~~at cost~~, computer tapes of the ~~health facility~~ reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 443.31, *in Sections 443.315, or 443.317,* unless the office determines that an individual patient's rights of confidentiality would be violated.

SEC. 17. Section 443.34 of the Health and Safety Code is amended to read:

443.34. (a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office with the advice of the Health Policy and Data Advisory Commission.

(b) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this part if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) ~~Modifications to discharge data reporting requirements.~~ The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this part. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified in Section 443.31.

(d) ~~Reporting provisions for health facilities.~~ The office, with the advice of the commission, shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner which is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 443.31. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

The office, with the advice of the commission, shall adopt comparable modifications to the financial reporting requirements of this part for county hospital systems consistent with the purposes of this part.

(e) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this part. This modification authority shall not be construed to permit the office to administratively require the reporting of ambulatory surgery data items not specified in Section 443.315.

(f) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate

regulations, for modifications to professional health care services reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this part. This modification authority shall not be construed to permit the office to administratively require the reporting of professional health care services data items not specified in Section 443.317.

(g) Hospitals and ambulatory surgery sites which receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans shall not be required to report charge data required by paragraph (15) of subdivision (g) of Section 443.31, and by paragraph (13) of subdivision (b) of Section 443.315, or the health care professional license number as required by paragraphs (13), (14), and (19) of subdivision (g) of Section 443.31, and paragraphs (10) and (11) of subdivision (b) of Section 443.315, and the license number of the principal health care professional as required by paragraph (8) of subdivision (b) of Section 443.317.

(h) The office shall have the authority to make any examination of books and records the office deems necessary to verify the accuracy of any data or report submitted pursuant to this part. The costs incurred in conducting any such examination shall be borne by the office. However, if the director determines that any data or reports were deliberately falsified, or that the reporting entity was aware of untrue statements contained therein, the reporting entity shall be responsible for all these costs of investigation, and shall, in addition, be liable for a civil penalty of twice the amount of these costs.

SEC. 18. Section 443.35 of the Health and Safety Code is amended to read:

443.35. (a) The office, with the advice of the commission, shall maintain a file of all the reports filed under this part at its Sacramento office. Subject to any rules, the office, with the advice of the commission, may prescribe, these reports shall be produced and made

available for inspection upon the demand of any person, with the exception of hospital discharge abstract data which shall be available for public inspection unless the office determines that an individual patient's rights of confidentiality would be violated.

(b) Copies certified by the office as being true and correct copies of reports properly filed with the office pursuant to this part, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission which participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(c) The office, with the advice of the commission, shall compile and publish summaries of the data for the purpose of public disclosure. The commission shall approve the policies and procedures relative to the manner in which data is disclosed to the public. The office, with the advice of the commission, may initiate and conduct studies as it determines will advance the purposes of this part.

(d) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director and the commission with an annual report on changes that can be made to improve the public's access to data.

(e) In addition to its public liaison function, the office

shall continue the publication of aggregate industry and individual health facility cost and operational data published by the California Health Facilities Commission as described in subdivision (b) of Section 441.95 as that section existed on December 31, 1985. This publication shall be submitted to the Legislature not later than March 1 of each year commencing with calendar year 1986 and in addition shall be offered for sale as a public document.

(f) The price of reports and of summaries produced from data collected pursuant to this part may, at the option of the director, be established at up to 100 percent above the cost of production to cover, in part, the office's cost of processing such data. Amounts collected from the sale of reports and summaries shall be deposited in the California Health Data and Planning Fund.

SEC. 19. Section 443.36 of the Health and Safety Code is amended to read:

443.36. (a) Any health facility, *ambulatory surgery site, or carrier* which does not file any report as required by this part with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office, with the advice of the commission.

If a report is filed and later found to be blank, unreadable, or incomplete, the office may reject the report. The health facility, ambulatory surgery site, or carrier shall be notified of the rejection, and provided 15 days in which to file the report. The fifth day shall be considered the due date for the report, and the civil penalty of one hundred dollars ($100) a day will begin to accrue after that date.

(b) Any health facility which does not use an approved system of accounting pursuant to the provisions of this part for purposes of submitting financial and statistical reports as required by this part shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) *(1) Any carrier which, following submission of its first four reports, files three sequential reports or a total*

of four reports for quarters occurring within any 24-month period that have an unacceptable error rate, as defined by the office pursuant to Section 443.317, shall be liable for a civil penalty of not more than ten thousand dollars ($10,000). The amount shall be determined by the office. In determining the appropriate penalty amount, the office shall consider the extent of the errors, demonstrated efforts to improve the data, actual improvement shown over time, and other factors deemed relevant by the office. If the carrier files with the office (A) a statement that the unacceptable rate of error was caused by certain identified health care professionals, (B) identification of each health care professional by name, license number, office address and phone number, and mailing address if different from the office address, and (C) evidence sufficient to demonstrate that it has provided timely notice to each health care professional that claims filed with the carrier do not meet acceptable accuracy standards and has made reasonable, good faith efforts to improve the accuracy of the data submitted by each health care professional to the carrier, the carrier shall be relieved of liability under this subdivision.

(2) If one or more carriers are relieved of liability under this subdivision, the office may then contact the identified health care professionals. Each contacted health care professional shall be informed of the information provided by the carrier or carriers regarding that health care professional and shall be allowed to file a response within 30 days. The office shall evaluate the evidence filed by the carrier or carriers and any timely response filed by the health care professional. If the office determines that the health care professional (A) has filed an unreasonable percentage of claim forms that are incomplete, inaccurate, or both, and (B) has failed to demonstrate either reasonable, good faith efforts to improve claim accuracy and completeness or actual, substantial improvement in claim accuracy and completeness, the health care professional shall be liable for a civil penalty of not more than five thousand dollars ($5,000). The amount shall be determined by the office.

In determining the appropriate penalty amount, the office shall consider the extent of the errors, demonstrated efforts to improve the accuracy and completeness of claim forms, actual improvement shown over time, and other factors deemed relevant by the office.

(d) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility, *ambulatory surgery site, or carrier* be reviewed on appeal, and the penalty may be reduced or waived for good cause.

~~(d)~~

(e) Any money which is received by the office pursuant to this section shall be paid into the ~~General Fund~~ *California Health Data and Planning Fund.*

SEC. 20. Section 443.37 of the Health and Safety Code is amended to read:

443.37. Any health facility*, ambulatory surgery site, or carrier* affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within such greater time as the office, with the advice of the commission, may allow, and shall specifically describe the matters which are disputed by the petitioner.

A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, a hearing officer employed by the Office of Administrative Hearings, or a committee of the commission chosen by the chairperson for this purpose. If held before an employee of the office or a committee of the commission, the hearing shall be held in accordance with such procedures as the office, with the advice of the commission, shall prescribe. If held before a hearing officer employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Division

3 *of Title 2* of the Government Code. The employee, hearing officer, or committee shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

The employee of the office, the hearing officer employed by the Office of Administrative Hearings, the Office of Administrative Hearings, or the committee of the commission, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Section 11510 of the Government Code.

SEC. 20.2. Section 1343.05 is added to the Health and Safety Code, to read:

1343.05. This chapter shall not apply to any program developed under the authority of any of the following:

(a) Section 603 of federal Public Law 98-21.

(b) Section 986 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

(c) Section 9412 of the federal Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509).

(d) Section 4118(g) (1) and (2) of the federal Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

(e) Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 21. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall pay to the commissioner a nonrefundable application fee in the amount of four thousand dollars

($4,000) or, if the applicant is to offer only one type of specialized plan contract, two thousand five hundred dollars ($2,500) at the time of submission of the application.

(b) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the commissioner on or before the 15th day of December of each year, as a reimbursement of its share of all costs and expenses, including overhead, reasonably incurred in the administration of this chapter and not otherwise recovered by the commissioner under this chapter or from the General Fund, an amount as estimated by the commissioner for the ensuing year. The amount paid by each plan shall be five hundred dollars ($500) plus an amount up to but not exceeding twenty-six cents ($0.26) for each family unit enrolled in its plan in this state as of the preceding June 30th, and shall be fixed by the commissioner by notice to all licensed plans on or before October 15th of each year. In determining the amount assessed, the commissioner shall consider all appropriations from the General Fund for the support of this chapter and all reimbursements provided for in this chapter. For the purpose of this section, a family unit is a household composed of one or more individuals.

(c) In addition to any fees specified above, the commissioner, effective July 1, 1993, shall annually assess each licensed full service health care service plan an amount not to exceed three thousand dollars ($3,000) to support the activities specified by Section 443.317. The Director of the Office of Statewide Health Planning and Development shall certify annually to the commissioner the amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439.

SEC. 22. Section 705 of the Insurance Code is amended to read:

705. *(a)* The commissioner shall require the payment of fifty-eight dollars ($58) in lawful money of the United States, in advance as a fee for filing an

application for each amendment of a certificate of authority authorizing any insurer to transact business in this state. Notwithstanding the provisions of Section 701 each insurer possessing a certificate of authority of indefinite term pursuant to such section shall owe and pay an annual fee of one hundred seventy-seven dollars ($177) in lawful money of the United States in advance on account of such certificate until its final expiration. Such fee shall be for annual periods commencing on July 1st of each year and ending on June 30th of each year and shall be due on each March 1st and shall be delinquent on and after each April 1st.

(b) In addition to any fees specified in subdivision (a), the commissioner, effective July 1, 1993, shall annually assess each insurer an amount not to exceed three thousand dollars ($3,000) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the commissioner the amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code.

SEC. 23. Section 11090 of the Insurance Code is amended to read:

11090. *(a)* Subject to the annual fee provisions as provided herein, every certificate of authority issued to a fraternal benefit society shall be for an indefinite term and shall expire with the expiration or termination of the corporate existence of the holder thereof unless sooner revoked by the commissioner. The commissioner shall require the payment of two thousand nine hundred fifty dollars ($2,950) in lawful money of the United States, in advance as a fee for filing an application for each original certificate of authority authorizing any fraternal benefit society to transact insurance in this state. Each society possessing a certificate of authority of indefinite term shall owe and pay an annual fee of one hundred seventy-seven dollars ($177) in lawful money of the United States in advance on account of such certificate

until its final expiration or revocation. Such fee shall be for annual periods commencing on July 1st of each year, and ending on June 30th of each year, and shall be due on each March 1st and shall be delinquent on and after each April 1st. A duly certified copy or duplicate of such certificate of authority shall be prima facie evidence that the holder is a fraternal benefit society within the meaning of this chapter.

(b) In addition to any fees specified in subdivision (a), the commissioner, effective July 1, 1993, shall annually assess each society possessing a certificate of authority an amount not to exceed three thousand dollars ($3,000) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the commissioner the amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code.

SEC. 24. Section 11509 of the Insurance Code is amended to read:

11509. *(a)* Every corporation subject to the provisions of this chapter shall annually, on or before the first day of March, file in the office of the commissioner a statement verified by at least two of the principal officers of the corporation, showing its condition and affairs as of the 31st day of December then next preceding, which shall be in such form as shall be required by the commissioner and shall contain statements relative to the matters required to be established as a condition precedent to maintaining or operating a nonprofit hospital service plan and to other matters as the commissioner shall prescribe.

Commencing with the annual statement to be filed on or before March 1, 1969, the commissioner shall require the payment of a fee for filing such statement. Such fee shall be in an amount estimated by the commissioner as the filing corporation's proportionate share of the costs of the department in administering the provisions of this

chapter in that calendar year with respect to the operations of all corporations required to file an annual statement. In making the estimate of such costs the commissioner shall take into account all other fees and charges, except those for examinations and agents, paid or to be payable to the department in such calendar year by such corporations and shall, on or before the first day of February, certify to each such corporation holding a certificate of authority under Section 11504, the amount of the fee to be paid by it pursuant to this section. The total amount of fees and charges, except charges payable in connection with examinations made pursuant to Section 736 and agents' license fees, whether imposed by this section or otherwise, to be collected by the commissioner from corporations subject to this chapter shall not exceed for any calendar year an amount equal to seven cents ($0.07) for each individual or family unit shown as covered by a hospital service contract in the annual statements filed under this section for the preceding calendar year.

The Legislature finds the accounts between the corporations subject to this chapter and the commissioner concerning the fees due under this section have not yet been settled for the calendar year 1969 or any subsequent period of time. For the calendar year 1969 and all subsequent calendar years the amounts of fees payable under this section shall be those prescribed by the wording of this section as amended at the 1970 Regular Session of the Legislature.

(b) In addition to any fees specified in subdivision (a), the commissioner, effective July 1, 1993, shall annually assess each insurer an amount not to exceed three thousand dollars ($3,000) to support the activities specified by Section 443.317 of the Health and Safety Code. The Director of the Office of Statewide Health Planning and Development shall certify annually to the commissioner the amount to be assessed. Moneys collected pursuant to this subdivision shall be deposited in the California Health Data and Planning Fund, created pursuant to Section 439 of the Health and Safety Code.

SEC. 25. Part 8.5 (commencing with Section 2020) is added to Division 2 of the Labor Code, to read:

PART 8.5. EMPLOYEE HEALTH INSURANCE

CHAPTER 1. GENERAL PROVISIONS

Article 1. Title and Purpose

2020. This part shall be known and may be cited as the Health Insurance Act of 1990.

2020.5. It is the purpose of this part to ensure that all persons in California are provided basic health care coverage. Further, it is intended that employer-sponsored health care programs offer employees coverage for dependents, the costs of which would be determined through employer-employee agreements. Finally, it is intended that this part encourage methods whereby employees of small firms can be included in both large group purchasing and risk-sharing pools so that the cost of health insurance to small businesses is equalized.

2021. This part shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that are more favorable to the employees than the basic benefits required by this part.

Article 2. Definitions

2022. Unless the context requires otherwise, the definitions set forth in this article govern the construction of this part.

2022.1. "Administering agency" means the Franchise Tax Board, and, if the Franchise Tax Board has contracted with the Employment Development Department for the enforcement of the tax on gross payrolls, with respect to provisions relating to those taxes, "administering agency" means the Employment Development Department.

2022.15. "Carrier" means any insurer, health care service plan, nonprofit hospital service plan, self-funded employer-sponsored plan, multiple employer trust, or Taft-Hartley Trust as defined by federal law, authorized to pay for health care services in this state.

2022.2. "Department" means the State Department of Health Services.

2022.25. "Dependent" means the spouse, dependent child up to age 22, permanently disabled child, or legally dependent parent of a covered employee.

2022.3. "Employee" means any person who works for any employer.

2022.35. "Employer" means any person, partnership, corporation, association, or public or private agency employing for wages or salary one or more persons to work in this state, and includes self-employed persons.

2022.4. "Fund" means the California Health Plan Fund.

2022.45. "Health benefits plan" means health insurance or other health coverage on a group plan, or both, which provides benefits equal to those provided pursuant to Chapter 3 (commencing with Section 2040).

2022.5. "Small low wage employer" means an employer with less than 50 full-time equivalent employees whose average wages per full-time-equivalent employee are below twenty thousand dollars ($20,000) per annum.

2022.55. "Other available health coverage" means any of the following:

(a) Insurance available at the place of employment.

(b) Medi-Cal.

(c) Medicare.

(d) Other state and federal health care coverage provided through other provisions of law.

(e) Health insurance policies purchased by the insured individual.

2022.6. "Physician and surgeon," for purposes of this part, means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic

Initiative Act, or a podiatrist with a certificate to practice podiatric medicine issued pursuant to Article 22 (commencing with Section 2460) of Chapter 5 of Division 2 of the Business and Professions Code.

2022.65. "Principal employer" means the employer for whom any employee works the largest number of hours in any month.

2022.7. "Taxable gross payroll" means that portion of an employer's gross payroll attributable to those employees who are not covered by a health benefits plan.

2022.75. "Wages" means all renumeration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer or his or her employer.

2022.8. "Supplemental policy" means health care coverage for services not included in the basic health care coverage provided under this division, and includes coverage for dental care, mental health services, long-term care, vision care, treatment of chemical dependency, and other services mutually agreed upon by the carrier and the purchaser.

CHAPTER 1.5. THE CALIFORNIA HEALTH PLAN COMMISSION

2023. (a) There is in the state government, the California Health Plan Commission, which shall be an independent authority.

(b) Membership of the commission shall be comprised of the following:

(1) Eight persons appointed by the Governor for four-year terms, as follows:

(A) Two persons who shall represent businesses with 50 or more employees.

(B) One person who shall represent businesses with less than 50 employees.

(C) One person who shall represent self-employed individuals.

(D) Two physicians or surgeons licensed under Chapter 5 (commencing with Section 2000) of Division 2

of the Business and Professions Code and in the active practice of medicine.

(E) One registered nurse.

(F) One representative of disability insurers provding coverage of hospital, medical, and surgical expenses.

(2) Four persons appointed by the Speaker of the Assembly, for four-year terms, as follows:

(A) One person who shall represent employee organizations.

(B) One person who shall represent county governments.

(C) One person representing a hospital.

(D) One person representing a health care service plan, as defined in subdivision (b) of Section 1373.10 of the Health and Safety Code.

(3) Four persons appointed by the Senate Committee on Rules for four-year terms as follows:

(A) One person who shall represent businesses with less than 50 employees.

(B) One person who shall represent employee organizations.

(C) Two persons who are consumers at large. These persons shall not be representative of any of the entities detailed in this section. In appointing these persons, the Senate Rules Committee shall designate which of the two shall serve on the cost containment committee, the health care contracting committee, and the medical standards committee established in Sections 2023.1, 2023.2, and 2023.3.

(c) Members of the commission shall receive actual necessary traveling expenses and a per diem allowance of $100 for each day spent in meeting of the commission over the commission committees.

(d) A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be made by the original appointing authorities for the unexpired term.

(e) The commission shall reimburse from the Health Care Trust Fund all public or private agencies or persons

for any and all services necessary to effectuate the purpose of this chapter provided by these public or private agencies or persons.

(f) The commission shall develop recommendations to carriers and employers on incentives, including premium cost-sharing ratio reductions, for employees and dependents with high-risk health factors who participate in a program approved by the employer to reduce the high-risk factors.

2023.1. (a) The commission shall establish a cost containment committee.

(b) Membership of the committee shall be taken from commission membership as follows:

(1) Two persons representing businesses with 50 or more employees.

(2) Two persons representing businesses with less than 50 employees.

(3) Two persons representing employee organizations.

(4) One person representing a hospital.

(5) One person representing a physician or surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(6) One person representing registered nurses.

(7) One person representing a health care service plan regulated under the Knox-Keene Health Care Services Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(8) One person representing disability insurers providing coverage of hospital, medical and surgical expenses.

(9) One person representing consumers at large.

(c) The committee shall perform the functions set forth in Article 2 (commencing with Section 2180) of Chapter 7.

2023.2. (a) The commission shall establish a committee to contract for health care services for those electing to contribute to the Health Care Trust Fund to obtain health coverage.

(b) Membership of the committee shall be taken from commission membership, as follows:

(1) Two persons representing a business of 50 or more employees.

(2) Two persons representing businesses of fewer than 50 employees.

(3) One person representing self-employed individuals.

(4) One person representing counties.

(5) One person, who shall have been appointed by the Speaker of the Assembly, representing employee organizations.

(6) One person representing consumers at large.

(c) The committee shall perform the functions set forth in Article 2 (commencing with Section 2100) of Chapter 5.

2023.3. (a) The commission shall establish a committee to make recommendations on medical standards.

(b) The membership of the committee shall be taken from the commission membership as follows:

(1) Two persons representing businesses with 50 or more employees.

(2) One person representing employee organizations.

(3) One person representing hospitals.

(4) Two persons representing physicians or surgeons licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(5) One person representing registered nurses.

(6) One person representing health care service plans licensed under the Knox-Keene Health Care Services Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(7) One person representing disability insurers providing coverage of hospital, medical and surgical expenses.

(8) One consumer at large.

(c) Membership on the committee shall also include six other physicians or surgeons licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the

Business and Professions Code or the Osteopathic Act and in the active practice of medicine.

(1) No physician member of the panel shall practice in the same medical specialty as any other member nor conduct his or her primary practice in the same county as any other physician member.

(2) Appointments of these members shall be for four-year terms, appointed as follows:

(A) Two by the Governor, at least one of whom shall have experience in the administration of utilization review system.

(B) Two by the Senate Rules Committee, at least one of whom shall have experience in the administration of utilization review systems.

(C) Two by the Speaker of the Assembly, at least one of whom shall have experience in the administration of utilization review systems.

(c) A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term and shall be made by the original appointing authority.

(d) The committee shall perform the functions set forth in Article 1 (commencing with Section 2165) of Chapter 7.

CHAPTER 2. COVERAGE

2030. (a) Every employer shall provide basic minimum health care coverage for each employee and his or her uninsured dependents pursuant to this part or pay a premium as set forth in Sections 2065 and 2070 into the California Health Plan Fund to provide coverage.

(b) Every individual who is not otherwise covered shall either purchase basic health coverage for the individual and his or her uninsured dependents or pay an assessment into the California Health Plan Fund as described in Sections 2065 and 2070.

2030.5. Every employer required to provide health care coverage pursuant to this part may do either of the

following:

(a) Select that coverage from any carrier.

(b) Provide coverage through self-funded employer-sponsored plans.

(c) Pay a premium in an amount set forth in Section 2065 into the California Health Plan Fund.

2031. (a) Every employer purchasing coverage from any carrier shall pay at least the following:

(1) Seventy-five percent of the cost of the least costly basic minimum health care coverage for each employee which the employer offers.

(2) Fifty percent of the cost of the least costly basic minimum health care coverage which the employer offers for each of the employee's dependents.

(b) To the extent that the employee is responsible for paying all or a part of the cost of health care coverage required by this part, the employer shall withhold those amounts from the employee's salary and wages.

(c) The sharing ratios of this part shall not become operative with respect to low-income and moderate-income employees until the Health Care Coverage Commission determines or develops a mechanism to assure affordability to low-income working families.

2031.5. Each employer shall continue payments for health care coverage for any employee who is hospitalized or otherwise prevented by sickness or injury from working and earning wages, and for whom sick leave benefits are exhausted. This obligation shall continue for three calendar months following the month during which the employee became hospitalized or disabled from working, or the month the employee becomes eligible for other public or private coverage, whichever occurs first.

2032. This part does not require an employer to provide health care coverage for any employee or dependent, or both, who is covered as a dependent under a health care plan, health insurance plan, hospital service plan, or self-funded employer-sponsored plan which has benefits meeting the requirements of this part.

2032.5. Nothing in this chapter shall be construed to limit the right of employees to bargain collectively for different health care coverage, if the protection provided by the negotiated plan is at least equivalent to the protection afforded by this chapter. This chapter shall be applicable with respect to any employees who do not receive at least this level of protection or who are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party.

2033. An employer that provides basic health care coverage pursuant to this chapter shall not be required to provide health care coverage pursuant to this article with respect to any employee or dependent if the employee waives enrollment of the employee or the employee's dependent in writing pursuant to Section 2031.

2033.5. An employee shall pay for any portion of the premium not covered by the employee's employer.

2034. (a) An employee may not waive basic health care coverage for the employee or the employee's dependents to avoid duplicate coverage except as provided in this section.

(b) An employee, at the employee's option, may waive basic health care coverage for the employee or the employee's dependent or both, but only for the period the employee demonstrates that the employee or the dependent, or both, has at least basic health care coverage.

(c) A dependent minor who is employed (or a parent or guardian on the behalf of a dependent minor under 12 years of age) may waive basic health care coverage provided by the dependent minor's employer, but only for the period that the dependent minor (or parent or guardian) demonstrates that the dependent minor has at least basic health care coverage.

(d) In the case of an individual who is an employee with respect to more than one employer, the employee may waive basic health care coverage from any employer, but only if (and for the period of time as) the employee demonstrates that the employee or each

dependent, or both, has basic health care coverage.

(e) An employee who waives health care coverage pursuant to this section shall notify his or her employer immediately if the duplicate coverage is terminated, and shall enroll in the employer's health care plan effective not later than the first day of a calendar month following 30 days from the date of the termination of the duplicate coverage.

2034.5. An employer shall not fail or refuse to hire, and shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child or other dependent and the employer would be required by this article to provide basic health care coverage for the spouse or child or other dependent in order to obtain the employer health care credit. A violation of this section constitutes unlawful discrimination within the meaning of Section 51 of the Civil Code, and an unfair business practice within the meaning of Section 17200 of the Business and Professions Code.

2035. Employers may form associations for the purpoe of providing the health care coverage required by this part. Employers who form associations may do the following:

(a) Pool their employees in order to obtain group, rather than small-group or individual, rates and coverage.

(b) Provide for self-funded employer-sponsored health care coverage.

(c) Notwithstanding any other provision of law, nothing shall preclude individuals or employers from forming legitimate associations solely for the purposes of negotiating for and securing health coverage.

2035.5. Any employer who fails to provide the health care coverage required by this part shall be liable to pay for all health care costs incurred by an eligible employee during the period in which the employer failed to provide coverage.

2036. Employers providing coverage pursuant to this part shall not be required to pay for benefits when the beneficiary is entitled to receive those benefits under any

workers' compensation or employers' liability law for the injury or illness or any other third-party liability policy or law.

2036.5. (a) All colleges, all universities, and all other comparable insitutions of higher learning shall assure that all full-time students are covered for the basic minimum set of services. This may be accomplished by, but not limited to, documentation of parental or spousal coverage or through the imposition of student fees.

(b) For purposes of this section, full-time students are all students, including those who are also employees of the college, university, or other comparable institution of higher learning, enrolled in courses at 50 percent or more of the normal credit load for full-time students.

(c) Subsidies through the state purchasing pool in Article 4 (commencing with Section 2150) of Chapter 6 shall only be available to students covered through their parents or their employment which otherwise qualify.

CHAPTER 3. HEALTH CARE BENEFITS

Article 1. Covered Benefits

2040. The basic minimum health care coverage shall include all of the benefits and services listed in this article.

2040.1. Hospital inpatient care in, a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, including all of the following benefits and services:

(a) Semi-private room, including meals, general nursing services, and private room and special diets when prescribed as medically necessary.

(b) Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, anesthesia, radiology, laboratory, and other diagnostic services.

(c) Drugs and medications administered while an inpatient.

(d) Dressings, casts, equipment, oxygen services, and

radiation therapy.

(e) Inhalation therapy following prior authorization.

2040.2. Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

(a) Surgical services performed by a physician and surgeon.

(b) Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.

(c) Dressings, casts and use of castroom, anesthesia, and oxygen services when medically necessary.

(d) Blood derivatives and their administration, and whole blood when a volunteer blood program is not available to the enrollee.

(e) Home, office, and hospital visits by a physician and surgeon.

(f) Radiation therapy, and chemotherapy of proven benefit.

(g) Preventive services for health maintenance of minors, including well-child examinations, health evaluations, physical examinations for early detection and diagnosis of disease or other conditions, immunizations and vaccinations in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987, and pap smears and mammograms under the periodicity schedules approved by the commission.

(h) Medical and surgical consultation by a physician and surgeon.

(i) Sterilization.

(j) Nothing in this section shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services.

(k) This section shall also include these services when provided in a licensed nonprofit primary care clinic licensed pursuant to Section 1204 of the Health and Safety Code.

2040.3. Comprehensive maternity and perinatal care, including the services of a physician and surgeon, and all

necessary hospital services are covered services. Nothing in this section shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services.

2040.4. Emergency care, including emergency ambulance transportation is a covered service.

2040.5. Covered services include plastic and reconstructive surgical services limited to the following:

(a) Surgery to correct a physical functional disorder resulting from a congenital disease or anomaly.

(b) Surgery to correct a physical functional disorder following an injury, or incidental to surgery covered by the minimum basic health care coverage.

(c) Reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury. Internal breast prosthesis required incidental to the surgery is a covered service.

2040.6. Preventive care including periodic routine physical exams and proven preventive procedures and screenings for well-children in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987, when prescribed by a physician and surgeon, or by a nurse practitioner within his or her scope of practice, is a covered benefit.

2040.7. (a) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration for approved indications, generic equivalents listed as substitutable in the federal Food and Drug Administration publication, "Approved Drug Products With Therapeutic Equivalence Evaluation", are covered benefits.

(b) Health benefit plans may impose cost-containment measures, including, but not limited to, requiring the use of generic drugs, or the use of a drug formulary.

(c) Notwithstanding subdivision (a), basic health care coverage shall provide for a copayment of 25 percent for generic prescription drugs and for nongeneric prescription drugs where a generic prescription drug is

not available and 50 percent for nongeneric prescription drugs where a generic prescription drug is available.

2040.8. Mental health benefits, including all of the following, are covered benefits:

(a) Inpatient care or acute residential care for a period of at least 10 days in each calendar year.

(b) At least 15 outpatient visits in each calendar year.

2040.9. This part shall not be construed to prohibit an insurance carrier's ability to impose cost-control mechanisms, including, but not limited to, prior authorization.

Article 2. Excluded Benefits

2041. The benefits and services listed in this article shall not be included as part of the basic minimum health care coverage required by this part. Coverage of these services shall remain subject to labor negotiations, individual choice, or individual payment by patients.

2041.1. Services which are not medically necessary for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though the services are not specifically listed as exclusions, are excluded.

2041.2. Any services which are received prior to the enrollee's effective date of coverage are excluded.

2041.3. Custodial, domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required are excluded. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

2041.4. Personal or comfort items, or a private room in a hospital unless medically necessary, are excluded.

2041.5. Emergency facility services for nonemergency conditions are excluded.

2041.6. Excluded services include those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:

(a) Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(b) Outmoded, not efficacious, or not sufficiently cost-effective to be covered by the minimum basic benefit package as determined pursuant to Article 1 (commencing with Section 2040).

2041.7. Transportation except as specified in Section 2150.7 of listed benefits is excluded.

2041.8. Implants, except pacemakers, intraocular lenses, and artificial hips are excluded.

2041.9. Sex change operations, investigation of or treatment for infertility, reversal of sterilization, conception by artificial means, and contraceptive supplies and devices are excluded.

2042. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care are excluded.

2042.1. Speech, occupational, and physical therapy are excluded.

2042.2. Long-term care benefits including home care, skilled nursing care, respite, and hospice care are excluded except as a plan shall determine they are less costly alternatives to the basic minimum packages.

2042.3. Dental services and services for temporomandibular joint problems are excluded, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible and provided the enrollee is eligible for covered services at the time that services are provided.

2042.4. Mental health services are excluded.

2042.5. Treatment of chemical dependency is excluded.

2042.6. Obesity treatment and weight loss programs are excluded.

2042.7. Cosmetic surgery, including treatment for complications of cosmetic surgery is excluded, except as specifically provided in Section 2151.3.

2042.8. Excluded benefits include medical services received from or paid for by the Veterans' Administration, benefits or services that are covered under the terms of any automobile medical, automobile no fault or liability, underinsured or uninsured motorist, or similar contract of insurance, and benefits paid under Division 4 (commencing with Section 3200) or Division 4.5 (commencing with Section 6100) or any employers' liability law or federal law which provides benefit payments for the injury or illness.

2042.9. Conditions resulting from acts of war (declared or not) are excluded.

2043. Any service or supply not specifically listed as a covered service is excluded.

Article 3. Operative Date

2045. On January 1, 1992, the Auditor General shall determine the percentage of employees who are not covered by the voluntary extension of health coverage by their employers. This number shall be explained in a report to the Legislature and the Governor delivered by June 1, 1992. On January 1, 1995, the Auditor General shall determine the percentage of employees who are still not covered by the voluntary extension of coverge by their employers. This determination shall be explained in a report to the Legislature and the Governor delivered no later than January 1, 1995. This chapter shall only become operative if the Auditor General finds that 90 percent of those who were uninsured, as determined by the June 1, 1992, Auditor General study, are still not covered on January 1, 1995.

CHAPTER 4. FISCAL PROVISIONS

Article 1. Funding

2050. There is hereby established the California Health Plan Fund.

2051. It is the intent of the Legislature that all money in the fund will be available to the commission upon appropriation by the Legislature for the purposes of this part. Money in the fund shall be used exclusively for the purposes of this part.

2052. All premiums and other payments collected under Sections 2060 and 2070 shall be deposited in the fund.

2053. It is the intent of the Legislature that all the money in the Hospital Service Account, Physician Service Account, and the Unallocated Account of the Cigarette and Tobacco Products Surtax Fund created by Section 30122 of the Revenue and Taxation Code be appropriated, pursuant to future legislation, to the fund. However, if any portion of the funds received cannot be used for purposes consistent with Section 30122 of the Revenue and Taxation Code that are applicable to the money, the commission shall return the appropriation to the appropriate account of the Cigarette and Tobacco Products Surtax Fund.

2054. It is the intent of the Legislature that there be, pursuant to future legislation, an annual appropriation from the General Fund to the fund in an amount equal to 100 percent of the 1988–89 General Fund spending on the Medically Indigent Services Program increased annually by the percentage increase in the California Necessities Index.

2055. (a) The State Department of Health Services shall seek federal approval for the inclusion of Medi-Cal recipients as participants in the plan, and the use of federal and state funds devoted to that program by the plan. If approval is received, it is the intent of the Legislature that money that would otherwise be spent on that program shall be used by the fund.

(b) The State Department of Health Services shall seek all appropriate federal waivers to maximize federal financial participation. The department shall report to the appropriate committees of the Legislature on any waivers received.

Article 2. Health Premium Surcharges for Small Employers and Individuals

2060. It is the intention of the Legislature to fund this part from the premiums and surcharges imposed by this article and Article 3 (commencing with Section 2070) upon the enactment of subsequent authorizing legislation. Nothing in this part authorizes the imposition of any tax for purposes of Section 3 of Article XIII A of the California Constitution.

2060.5. Eligible employers and employees who opt to purchase health care coverage through the Health Care Trust Fund program shall each pay their portion of the premium by paying the health premium surcharge as provided in Section 2065.

2061. (a) The monthly premium for participation of eligible employees of employers of less than 50 full-time equivalent employees shall be 8 percent of the gross payroll attributable to employees who are not covered by a health benefits plan.

(b) The premiums shall cover the cost of providing basic minimum benefits, and shall cover administrative costs. Program administrative costs shall account for no more than 6 percent of the total premiums collected.

2062. Employee contributions toward the premium shall be 2 percent of gross wages above the federal proverty level.

2063. Employer and employee contributions toward the premium for part-time employees shall be prorated to reflect the percentage of full-time (40 hours per week) work performed by that employee.

2064. Employer and employee contributions toward the premium for seasonal employees shall be prorated to reflect the number of weeks or parts thereof worked by

the employee.

2065. For those employers and employees who opt to obtain coverage for the minimum basic benefits by purchasing coverage through the Health Care Trust Fund, a health premium surcharge is hereby imposed as follows:

(a) On that portion of the employer's gross payroll that is attributable to employees who are not covered by a health benefits plan, a surcharge of 8 percent.

(b) On the taxable income of every self-employed or other individual who is not covered by a health benefits plan, a surcharge of 4 percent on income above the federal poverty level and below 200 percent of the federal poverty level, and a surcharge of 8.5 percent on all income above 200 percent of the federal poverty level.

(c) On the gross wages of each employee who is not covered by a health benefits plan, a surcharge of 2 percent on wages above the federal proverty level.

2066. During its first three years of business, every small business employer's surcharge imposed under Section 2065 shall be reduced to the following amounts:

(a) During the first year following commencement of business, 25 percent of the amount specified in Section 2065.

(b) During the second year, 50 percent of the amount specified in Section 2065.

(c) During the third year, 75 percent of the amount specified in Section 2065.

2067. This article shall be operative only upon the enactment of subsequent legislation imposing the premiums or surcharges.

Article 3. Large Employer Health Care Assessments

2070. Upon the operative date of subsequently enacted legislation imposing an employer health care premium contribution for employees, each employer of over 50 full-time equivalent employees shall be assessed yearly an employer health care premium contribution for each employee and dependent in an amount set by the

commission. The employer health care premium contribution for each employee shall be calculated annually to be equivalent to 100 percent of the highest annual premium for basic health care coverage offered during the preceding calendar year by health insurers plus an adjustment reflecting the increase in the Consumer Price Index estimated for the taxable year by the commission using urban area indices for California, multiplied by the number of employees employed during the employer's taxable year and their dependents. In any case where the employer health care contribution is too low because the number of employees or dependents, or both, increases after the assessment is made, a supplemental assessment reflecting the increase shall be made. However, a large employer may choose the premium surcharge schedule under Article 2 (commencing with Section 2060) for part-time and seasonal employees provided that all such employees of the employer are treated in a equal manner. For purposes of this section, a seasonal employee includes only employees hired for less than 90 days and a part-time employee includes only employees of less than 25 hours per week.

2071. Each employer that provides to its employees and their dependents at least basic health care coverage in accordance with the provisions of this chapter shall be entitled to a credit against the employer health care contribution assessed pursuant to Section 2070 in an amount equal to that assessment. An employer may claim this employer health care credit by certifying under penalty of perjury that the coverage provided by the employer covers at least the benefits listed in Article 1 (commencing with Section 2040) of Chapter 3.

2072. (a) The total amount of an employer's employer health care contribution shall be due and payable to the Franchise Tax Board at the same time and in the same manner as the employer's personal or corporate income tax return is due pursuant to Chapter 17 (commencing with Section 18401) and Chapter 18 (commencing with Section 18551) of Part 10 of, or

Chapter 19 (commencing with Section 25401) of Part 11 of, Division 2 of the Revenue and Taxation Code, as applicable.

(b) The Franchise Tax Board shall design tax returns to provide for a schedule listing the employer health care contribution, the employer health care credit, the health plan certified pursuant to Section 2071, and the waiver described in subdivision (b) of Section 2034.

(c) Chapter 17 (commencing with Section 18401) to Chapter 24 (commencing with Section 19451), inclusive, of Part 10 of Division 2 of the Revenue and Taxation Code relating to the methods of collection of personal income tax and to assessments and penalties for failure to declare or pay tax liability, and Chapter 19 (commencing with Section 25401) to Chapter 24 (commencing with Section 26421), inclusive, of Part 11 of Division 2 of the Revenue and Taxation Code relating to the methods of collection of corporate income tax and to penalties for failure to declare or pay tax liability, shall be applicable to contributions due under this section.

(d) (1) The costs of the Franchise Tax Board in administering the collection of the contributions shall be reimbursed by the commission from the Health Care Trust Fund.

(2) Notwithstanding any other provision of law, information provided to the Franchise Tax Board pursuant to this article shall be available to the commission.

2073. Any employer that elects to receive the employer health care credit and then fails to provide basic health care coverage, in addition to any other assessments and penalties, shall be barred from the option of electing to receive the employer health care credit for a period of two years.

2074. In cases where an employer that has elected to receive the employer health care credit and then fails to provide basic health care coverage or otherwise comply with this chapter through neglect, inadvertence, or good faith mistake, or in cases in which the commission in its discretion expressly determines justice would be better

served, the commission may enter into a settlement with the employer by which the employer may voluntarily agree to submit to the imposition of the penalty imposed by the commission in lieu of any or all penalties imposed under Sections 2072 and 2073. A settlement pursuant to this section may include the waiver of past health care contributions due. The commission may establish a schedule of penalties or range of penalties by regulation.

2075. The California Health Plan Fund is hereby created in the State Treasury. Revenues collected pursuant to this article and as otherwise provided by law shall be deposited in the California Health Plan Fund. All moneys in the fund shall be available to the commission for the purposes of this chapter upon appropriation by the Legislature.

2076. This article shall become operative only upon the operative date of subsequent legislation imposing the employee health care premium contribution upon employers.

CHAPTER 5. ADMINISTRATION

Article 1. General Provisions

2080. The Franchise Tax Board may contract with the Employment Development Department for the collection of those health premium surcharges imposed on the gross payroll and wages of employers and employees pursuant to Section 2065.

2081. (a) The surcharge imposed on gross payrolls by this part shall be paid on the 15th day of the second month following the month for which the taxable payroll is computed.

(b) All other surcharges imposed under this part shall be paid on the same day that taxes are required to be paid under Part 10 (commencing with Section 17001) of Division 2 of the Revenue and Taxation Code.

2082. Any taxpayer subject to a surcharge on employer gross payrolls shall file with the administering agency a return of taxes on or before the 15th day of the

month following the month for which the payroll is computed.

2083. Any other taxpayer subject to surcharges under this part shall file with the administering agency a return of taxes at the same time the taxpayer is required to file a return of taxes under Part 10 (commencing with Section 17001) of Division 2 of the Revenue and Taxation Code.

2084. (a) All revenues collected pursuant to taxes imposed by this chapter shall be transferred to the California Health Plan Gross Payroll and Income Tax Fund, which is hereby established.

(b) All moneys in the fund created by subdivision (a) shall, upon appropriation by the Legislature, be available for the following purposes:

(1) For refunds and credits under this part.

(2) The balance shall be allocated to the California Health Plan Fund.

2085. The administering agency, in the enforcement of this part, shall, as soon as practicable after a return is filed under this part, examine it and determine the correct amount of the tax.

2086. If the administering agency determines that the tax disclosed by the original return is less than the tax disclosed by its examination, it shall mail a notice or notices to the taxpayer of the deficiency proposed to be assessed.

2087. Notwithstanding any provision to the contrary, any interest, penalty, or addition to any tax imposed under this division may be assessed and collected in the same manner as if it were a deficiency.

2088. Each notice shall set forth the reasons for the proposed additional assessment and the computation thereof.

2089. Within 60 days after the mailing of each notice of additional tax proposed to be assessed, the taxpayer may file with the administering agency a written protest against the proposed additional tax, specifying in the protest the grounds upon which it is based.

2090. If no protest is filed, the amount of the

deficiency assessed becomes final upon the expiration of 60 days.

2091. If a protest is filed, the administering agency shall reconsider the assessment of the deficiency and, if the taxpayer has so requested in the protest, shall grant the taxpayer or the taxpayer's authorized representative or representatives an oral hearing. The administering agency may act upon the protest in whole or in part. If the administering agency acts on the protest in part only, the remaining protest shall continue to be under protest until the administering agency acts on that part.

2092. (a) The administering agency's action upon the protest, whether in whole or in part, is final upon the expiration of 30 days from the date when it mails notice of its action to the taxpayer, unless the taxpayer appeals in writing from the action to the State Board of Equalization.

(b) The appeal shall be addressed and mailed to the State Board of Equalization at Sacramento, California, and a copy of the appeal shall be addressed and mailed at the same time to the administering agency.

2093. The State Board of Equalization shall hear and determine the appeal and thereafter shall forthwith notify the taxpayer and the administering agency of its determination and the reasons therefor.

2094. The State Board of Equalization's determination becomes final upon the expiration of 30 days from the time of the determination, unless within the 30-day period, the taxpayer or the administering agency files a petition for a rehearing with the State Board of Equalization. In that event, the determination becomes final upon the expiration of 30 days from the time the State Board of Equalization issues its opinion on the petition.

2095. When a deficiency is determined and the assessment becomes final, the administering agency shall mail notice and demand to the taxpayer for the payment thereof. The deficiency assessed is due and payable at the expiration of 10 days from the date of the notice and demand.

2096. If the administering agency finds that the assessment or collection of a tax or deficiency for any current taxable period, current or past, will be jeopardized in whole or in part by delay, it may mail or issue notice of its findings to the taxpayer, together with a demand for immediate payment of the tax or deficiency declared to be in jeopardy, including interest and penalties and additions thereto.

Article 2. Health Care Contracting

2100. Any references to the committee that appear in this article shall refer to the committee of the California Health Plan Commission created to contract for health care services pursuant to Section 2023.2.

2100.5. Within 60 days of the appointment of the commission, the health care contracting committee shall convene its first meeting.

2101. California residents with no other available health insurance or coverage are eligible for basic health insurance under the plan established by this chapter for themselves and their dependents.

2102. Small businesses, self-employed persons, and partnerships with less than 50 employees may purchase basic health insurance through the commission for their employees and dependents.

2103. (a) The committee shall provide basic health coverage to persons receiving unemployment insurance benefits either by exercising the continuation options for employee's group health coverage or by purchasing or providing basic minimum health coverage.

(b) Basic health insurance provided pursuant to this article shall include all of the following as provided in Article 1 (commencing with Section 2040) of Chapter 3:

(1) Inpatient and outpatient hospital care.

(2) Professional services as determined by the commission.

(3) Prenatal care, well-child care, and such other preventive services as determined by the commission.

(4) Prescription drugs.

(5) X-ray services.

(6) Laboratory services.

(c) The plan shall also include other less expensive alternatives to the basic services specified in subdivision (b) which the committee determines can be provided at lower cost through a cost-controlled system.

2104. The committee may fulfill any of its responsibilities by hiring staff or contracting with any qualified third parties as it shall determine.

2105. The costs of the premium for basic minimum health coverage shall be as determined by the committee and shall be no higher than the premiums for state employees for comparable coverage.

2105.5. It is the intent of the Legislature that the public safety net institutions shall have sufficient revenue to remain economically viable and to provide care that is fully equal to community standards.

2106. (a) The committee shall, wherever possible, contract for delivery of health care at negotiated amounts.

(b) The committee shall give preference in contracting to plans which offer subscribers the best possible health care at the lowest possible cost.

(c) Health maintenance organizations, prepaid health plans, independent practice associations, county organized health systems, and other qualified health systems under the Knox-Keene Health Care Services Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), prudent purchaser organizations, and other health insurance plans certified by the Department of Insurance or Department of Corporations may bid for contracts with the committee.

(d) In areas where there are no qualified plans, the committee may contract for care with local medical societies, hospitals, counties, or community clinics or make such other alternative arrangements for basic health coverage as it finds feasible.

(e) The committee may provide for self-insurance where it determines it is cost-effective.

(f) The committee shall, in conjunction with the California Medical Assistance Commission, establish a transition plan to assist public safety net institutions in making improvements necessary to become a qualified participant in the health care delivery system established by this chapter.

2107. The committee shall give priority in contracting to those plans which have established methods for preventing and controlling overutilization of services including utilization review, case management, and small area analysis, which emphasize delivery of preventive and primary care services through appropriate rate structures and service delivery, and which have established reimbursement structures, and delivery mechanisms which minimize the duplication of costly specialized medical services and which minimize financial out-of-pocket expenses for covered medical services to persons with limited capacity to pay for medical care. Plans shall include existing public health care institutions where available.

2108. (a) Where possible, the committee shall offer a choice of at least three alternative plans. The committee shall provide each eligible person with a fair and accurate summary of the alternative plans. The committee shall also prescreen for accuracy and completeness the marketing and advertising materials of all participating plans.

(b) Plans shall be actuarially sound, self-supporting, and at risk.

(c) Plans which contract with the committee shall not charge subscribers for any additional premiums for the basic coverage of this chapter.

(d) All services covered under a contracting plan shall be readily available and reasonably accessible to all enrollees.

(e) Where a county organized health care system is available and meets the requirements of this part, it shall be one of the choices offered under such terms and conditions as shall be agreed upon with the committee.

2108.5. The committee shall make adjustments

necessary to provide optimal access for all children afflicted with conditions covered by the California Children's Services program. Plans contracting with children's hospitals shall consider utilizing the Pediatric Diagnostic Reimbursement Methodology as defined in Section 14087.21 of the Welfare and Institutions Code.

2109. Plans which contract with the committee shall have open enrollment for persons eligible under the plan, may not impose waiting periods, and may not deny coverage or participation based upon the medical or demographic characteristics of the subscriber.

2110. The committee shall develop and implement with the assistance of the Departments of Corporations, Health Services, and Insurance a mechanism for monitoring the quality and accessibility of the plans.

2111. The committee may, for cause and after notice and hearing, declare that a provider is outside the plan, and the provider shall not be reimbursed by any participating plan for services provided after the determination except emergency services, as determined by the committee.

2112. Each participating plan shall have a grievance resolution procedure approved by the committee and an advisory committee on the quality and accessibility of care and comprised of subscriber representatives.

2113. Financing and expenditures for the costs of the program shall be deposited and expended from a special trust fund devoted exclusively to the purposes of this program.

CHAPTER 6. SMALL GROUP HEALTH COVERAGE

Article 1. General Provisions

2115. It is the intent of the Legislature in enacting this chapter to resolve the following problems which small businesses encounter in purchasing basic health coverage:

(a) Guaranteed availability of coverage.

(b) Guaranteed renewability of coverage.

(c) Stability in premiums over time.

(d) Reductions in variability of premiums to only those actuarially predictable factors including age, family size, and type of benefit plan selected.

(e) Increased ability for small businesses to negotiate the price of coverage with carriers.

2116. (a) "Carrier" means any disability insurer, health care service plan, nonprofit hospital service plan, or multiple employer trust authorized to pay for health care services in this state, or any other entity which writes, administers, reinsures, provides stop-loss coverage for or otherwise provides health care coverage in the state.

(b) "Board" means the Board of Directors of the Reinsurance Fund.

(c) "Basic health plan" means health benefits coverage for the minimum benefits pursuant to Article 3 (commencing with Section 2040) of Chapter 3.

(d) "Health benefits coverage" means health care services which are provided, arranged or paid for by a small group carrier.

(e) "Eligible employee" means any person who works at least 80 hours per month for any single employer but does not include an employee who works on temporary or substitute basis. However, effective January 1, 1995, eligible employee means any employee who works for an employer who offers coverage to all employees in the employee's job classification.

(f) "Fund" means the Reinsurance Fund established pursuant to Article 3 (commencing with Section 2130).

(g) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group's health benefits plan following the initial enrollment period provided under the terms of such plan. An eligible employee or dependent shall not be considered a late enrollee if: (1) the request for enrollment is made within 30 days after termination of coverage provided under another group health benefits plan, if: (A) the individual had not initially requested coverage under such plan solely because he or she was covered under another

group health insurance plan, and (B) coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce; or (2) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 30 days after issuance of the court order.

(h) "Small group" means an employer which has in its total workforce no more than 50 full-time employees, which will be required to provide health coverage for its employees pursuant to Section 2030, and in which a bona fide employer-employee relationship exists.

(i) "Preexisting condition" means any condition which, during the six months immediately prior to the effective date of group health care coverage, had manifested itself in a manner which would have caused an ordinarily prudent person to seek diagnosis, care or treatment, or for which medical advice, care or treatment was sought, recommended or received.

Effective July 1, 1995, no preexisting coverage exclusion may be imposed by any carrier or any California resident required to be covered either as an employee, individual, or dependent.

(j) "Secretary" means the Secretary of Business, Transportation and Housing.

(k) "Small group carrier" means a carrier that writes, administers or provides health benefits coverage to small groups in this state.

(l) "Participating small group carrier" means a carrier which elects to participate in the Reinsurance Fund, pursuant to Article 3 (commencing with Section 2130).

2117. (a) Each small group carrier, except a self-funded employer, shall fairly and affirmatively market health benefits coverage to all small groups in the service area in which the carrier makes coverage available or provides benefits. Each small group carrier shall make available to each small group the carrier's basic health plan which includes at least the minimum benefits and may not reject an application from a small

group for a basic health plan if all eligible employees in the small group obtain health coverage.

(b) Health benefits coverage issued to small groups shall begin within 31 days of receipt of the small group's completed application. Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a small group carrier may not exclude any eligible employee or dependent who would otherwise be covered, on the basis of an actual or expected health condition of that employee.

(c) Every basic health plan is renewable with respect to all eligible employees, or dependents at the option of the policyholder or contract holder, except (1) for nonpayment of small group premiums; (2) for fraud or misrepresentation by the small group or, with respect to coverage of an individual insured, fraud or misrepresentation by the insured or the insured's representative; (3) where the small group ceases to be a small group.

(d) Except as expressly provided by this chapter, no law requiring the coverage or the offer of coverage of a health care service or benefit and no law requiring the reimbursement, utilization or consideration of a specific category of licensed health care practitioner shall apply to health benefits coverage issued to a small group.

(e) The secretary may, after consulting with the Commissioners of Insurance and Corporations, issue regulations necessary to carry out the provisions of this section, or delegate to the respective commissioners authority to issue such regulations. Enforcement of regulations issued pursuant to this subdivision shall be enforced by each carrier's licensing agency.

2118. (a) The only situations in which a small group carrier is not required to market or offer a basic health plan or accept applications for a plan are:

(1) Where the carrier's licensing agency determines that it will not have the capacity within the service area, or portion of the service area, in its network of providers, to deliver services adequately to the members of small

groups, because of its obligations to existing group contract holders and enrollees.

(2) The carrier's licensing agency finds that acceptance would place the carrier in a financially impaired condition.

(b) A small group carrier that ceases to offer coverage pursuant to this section may not enroll small groups, nor new groups of employers with more than 50 employees unless it resumes enrolling new groups of employers with less than 50 employees pursuant to Section 2117.

(c) A carrier is not required to accept application from a small group pursuant to Section 2117 unless all eligible employees, not otherwise insured, in the group obtain at least the minimum benefits set forth in Article 1 (commencing with Section 2040) of Chapter 3 from a small group carrier.

2119. (a) Small group carriers may not reject an eligible employee or his or her dependents for coverage offered pursuant to subdivision (a) of Section 2117, residing in the service area in which the carrier provides benefits, nor may the employee or dependent's coverage be terminated while they are still eligible, except for nonpayment of premiums or other good cause specified in subdivision (b) of Section 2117.

(b) Except in the case of a late enrollee, no preexisting conditions provision may exclude coverage for a period beyond six months following the insured's effective date of coverage. Such provision may only relate to a condition which, during the six months immediately prior to the effective date of group health care coverage, had manifested itself in a manner which would have caused an ordinarily prudent person to seek diagnosis, care or treatment, or for which medical advice, care or treatment was sought, recommended or received, or where the employee was pregnant on the effective date of coverage. Effective July 1, 1991, no preexisting condition exclusions may be applied by any carrier except to an individual who has not resided in California for at least six months.

(c) A small group carrier shall credit any preexisting

condition or waiting period with the amount of time a newly covered person was covered in this state by any group health care benefits program immediately prior to being enrolled in the carrier's program, if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage.

(d) All small group health benefits coverage covering employees who are residents in this state, except coverage provided by health care service plans licensed by the Department of Corporations, shall be subject to, and comply with, all statutory and regulatory requirements applicable to group policies of disability insurance issued in this state.

2120. Small group carriers shall elect to either comply with underwriting requirements set forth in Article 2 (commencing with Section 2125) or participate in the Reinsurance Fund established in Article 3 (commencing with Section 2130). The election shall be made biannually during an election period. The secretary may permit a carrier to modify its election at times other than the election period for good cause. All small group carriers under common ownership or affiliation shall make the same election for an election period. Any carrier which ceases to write, administer or otherwise provide small group coverage in this state shall continue to be governed by this chapter with respect to business conducted under this chapter which was transacted prior to the effective date of termination.

2121. (a) The secretary shall, after consultation with the Commissioners of Insurance and Corporations, issue regulations which are necessary to carry out the purposes of this chapter. The regulations shall be enforced by the Commisioner of Corporations in the case of carriers licensed under the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and by the Commissioner of Insurance in the case of other carriers. The California Small Group Reinsurance Fund shall operate subject to the supervision of its board of directors, and to the approval of the secretary.

2122. All provisions of this article shall apply to all small group carriers, whether they elect to do business as a small group carrier under Article 2 (commencing with Section 2125), or a participating small group carrier under Article 3 (commencing with Section 2130).

Article 2. Underwriting Standards

2125. The secretary may, after consultation with the Commissioners of Insurance and Corporations, permit a rate band of up to 60 percent for Article 2 carriers and 80 percent for Article 3 carriers if the secretary determines this is necessary to maintain market stability for small group purchasers and carriers during the "voluntary" period until January 1, 1995.

2125.5. Any small group carrier which writes or administers small group coverage in this state may elect to operate under this article, provided the carrier meets minimum financial standards which are established by its licensing agency for that purpose, and which are subject to review by the secretary.

2126. The following underwriting standards apply to small group carriers which elect to comply with this article.

(a) Geographic underwriting standards shall be limited to no more than four California regions. A small group carrier may divide the state according to reasonable criteria fully disclosed to prospective group contractors, so long as one geographic region in northern California includes the Counties of Alameda, Contra Costa, Santa Clara, San Francisco, and San Mateo, and one geographic region in southern California includes Los Angeles and Orange Counties. A health maintenance organization or preferred provider organization is not required to offer coverage in a region in which it does not have an adequate provider network to serve covered individuals.

(b) Within each geographic region established by a small group carrier, underwriting groups may be established by classes of enterprise. Where underwriting

groups are used, the carrier may establish no more than the following classes of enterprise to which each contracting employer group shall be assigned.

(1) Retail trade.

(2) Manufacturing.

(3) Agriculture.

(4) Transportation.

(5) Wholesale trade.

(6) Services industries.

(7) Professions.

(8) Construction.

(9) Miscellaneous.

(c) A small group carrier may not charge more than 30 percent more for the highest enterprise classification rate than for the lowest enterprise classification rate within each geographic region. The rates may vary by geographic region and enterprise classification, and within each geographic region and enterprise classification the rates may be adjusted by age and family size and for the type of basic minimum plan or supplemental benefits plan offered; however, the rates must reasonably reflect a carrier's actual experience within the geographic region and the enterprise classification. No other factors may be used. Carriers shall use only the following seven age brackets and four family size categories; provided however, that the specified age brackets may be combined:

(1) Age Brackets:

Under 20
20–29
30–39
40–49
50–59
60–64
65 and over

(2) Family Size Categories:

Single
Married couple
One adult and child or children

Married couple and child or children

(d) Rates for each small group may not be changed more frequently than every 12 months and renewal rates must be the same as rates for new business. Any rate credit must apply to all groups within an enterprise classification and may not result in a variation of rates by enterprise classification greater than that permitted by subdivision (b).

(e) Additional underwriting criteria including, but not limited to, medical underwriting or experience rating shall not be applied to the rating groups or individuals within a group eligible for coverage under this section.

2127. Small group carriers complying with subdivision (a) of Section 2126 and with underwriting and rating standards established by the federal Health Maintenance Organization Act as in effect on January 1, 1990, shall be deemed in compliance with this article, provided. These carriers limit their maximum rates for health coverage provided to small groups to one of the following:

(a) Thirty percent above the lowest rates they charge small groups for their basic health plans within each geographical region, adjusted for the benefits covered, age, and family size.

(b) The maximum rates for small groups permitted under the federal Health Maintenance Organization Act when adjusted community rating is utilized.

Each small group carrier subject to this section shall certify to its licensing agency when it elects to operate under subdivision (a) or (b).

Article 3. California Small Group Reinsurance

2130. (a) There is created a nonprofit corporation, to be known as the California Small Group Reinsurance Fund, consisting of all small group carriers in the state except those carriers electing to provide health benefits coverage in accord with the underwriting rules set forth in Article 2 (commencing with Section 2125). Carriers

participating in the fund shall be bound by the fund's plan of operation, as provided for in this article, and as promulgated by the board.

(b) No small group carrier may withdraw from participation in the fund, unless it ceases to write, renew, or administer small group health coverage to employees or individuals in this state; or ceases to be licensed to write or administer small group health coverage to employees in this state; or elects to become a carrier which complies with the rules set forth in Article 2 (commencing with Section 2125). A carrier shall have the option to elect to cease participating in the fund and to comply with rules set forth in Article 2 (commencing with Section 2125) during the biannual election period established by the secretary, provided that each contract issued by the carrier pursuant to this article shall nevertheless continue to be governed by this article until the end of the contract term.

(c) The board may permit a carrier to cease participation at times other than the biannual election period for good cause, provided, however, that the carrier shall be required to pay a continued prorated assessment for business issued pursuant to this article.

2131. The fund shall be governed by the board of directors, which shall be appointed by the secretary and composed of nine members, eight of whom shall represent carriers which reasonably reflect the different kinds of health care financing systems which participate in the fund. The ninth member of the board shall represent the secretary. The term of each board member shall be two years, except that of the members first appointed, four members shall have one-year terms. The secretary may remove a board member for good cause. The board shall hold an initial organizational meeting within 15 days following appointment.

2132. The board shall make an annual report to the carriers participating in the fund, and shall file such report with the secretary, the President pro tempore of the Senate, and the Speaker of the Assembly. The report shall summarize the activites of the program in the

preceding calendar year.

2133. The board shall have the specific authority to:

(a) Establish procedures for the operation of the board and the fund.

(b) Create a fund, under management of the board, to fund administrative expenses and claims.

(c) Establish procedures for the handling and accounting of assets and moneys of the fund.

(d) Sue or be sued, including taking any legal actions necessary or proper to protect the interests of the fund.

(e) Establish appropriate reinsurance rates and rate schedules and perform any other actuarial function appropriate to the operation of the fund.

(f) Provide reinsurance in accordance with the requirements of this article.

(g) Appoint appropriate committees as necessary to provide technical assistance in the operation of the fund.

(h) Borrow money to effect the purposes of the fund. Any notes or other evidence of indebtedness of the fund not in default shall be legal investments for carriers and may be carried as admitted assets.

(i) Establish rules, condition and procedures for the insurance of risks under this article.

(j) Employ and fix the compensation of employees.

(k) Recommend to the secretary assessments of carriers in accordance with Section 2144.

(l) Propose regulations to the secretary to provide for quarterly reporting of earned premium and earned premium equivalence by all small group carriers operating pursuant to this article.

(m) Purchase reinsurance coverage for the fund, if the board determines that reinsurance would be appropriate.

2134. The secretary shall, after consultation with the board, issue regulations necessary to implement the plan of operation of the fund. Regulations affecting carriers operating pursuant to this article shall be enforced by the Commissioner of Corporations in the case of carriers licensed under the Knox-Keene Health Care Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and by the

Commissioner of Insurance in the case of other carriers. The commissioners shall consult with one another and shall enforce regulations in a reasonably consistent manner.

2135. Within 90 days after its initial organizational meeting, the board shall submit to the secretary a proposed statewide plan of operation for the fund. The plan of operation shall be deemed approved if not disapproved by the secretary, acting after consultation with the Commissioner of Insurance and the Commissioner of Corporations, within 30 days after it is submitted. If no plan of operation is submitted at the end of 90 days, the secretary shall establish an interim plan of operation under which the fund shall operate until a substitute plan of operation is submitted by the board and approved by the secretary, as provided herein. The plan of operation shall provide for any matters required by or necessary to implement this article. At least annually the board shall file any modifications to the plan of operation, and those modifications shall be deemed approved if not disapproved by the secretary, acting after consultation with the Commissioner of Insurance and the Commissioner of Corporations, within 30 days after submission.

2136. The board shall establish the conditions for reinsuring small group health coverage by the fund using sound insurance principles and subject to appropriate state supervision.

2137. Every small group carrier participating in the fund shall retain the right to underwrite and rate all small groups using reasonable underwriting and actuarial techniques, subject to the restrictions imposed by Article 1 (commencing with Section 2115) and this article.

2138. A small group carrier may offer benefits additional to the minimum benefits set forth in Article 1 (commencing with Section 2040) of Chapter 3, but it may not reinsure the risk associated with those additional benefits with the fund.

2139. (a) Subject to the following, a participating small group carrier may cede, and the fund shall

indemnify the participating carrier for up to 85 percent of the cost of claims arising under small group coverages ceded by a participating carrier.

(b) The board shall develop annual reporting requirements for participating small group carriers to provide the fund with appropriate information concerning small group business which is reinsured by the fund. The board shall develop such reporting requirements in conjunction with the Commissioner of Corporations and the Insurance Commissioner.

(c) The board shall charge a reinsurance premium for reinsurance provided under this article. Reinsurance rates shall not exceed 150 percent of the average standard rate, using standard rating criteria for the first year of operation, and according to sound actuarial principles for each year thereafter. Premiums charged for reinsurance may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expense of providing the coverage.

(d) The board shall reduce the reinsurance premiums under this section to reflect limitations on the amount of risk that a federally qualified health maintenance organization may cede to the reinsurance pool pursuant to 42 U.S.C. 300e, et seq., and other restrictions imposed on federally qualified health maintenance organizations pursuant to 42 U.S.C. 300e, et seq.

(e) The board shall set rules and procedures for all of the following:

(1) Ceding and acceptance of risks.

(2) Ensuring that a participating carrier is properly administering any health care coverage ceded to the fund.

(3) Establishing minimum standards for ceded business.

(4) Referring to the secretary or to a carrier's licensing agency matters warranting their investigation or sanction.

2140. Rates for small group health coverage offered under this article shall be consistent with sound actuarial practices. No carrier may charge any small group more

than 40 percent above the lowest rate it charges for its basic health plan or supplemental benefits plan within each geographical region, adjusted for the benefits covered, age and family size.

2141. The age, family, and geographic variations for carriers operating under this section shall be the same as for those carriers under Section 2117.

2142. A carrier electing may not set rates for an individual small group purchaser based upon medical underwriting criteria or experience rating except at the initial offering.

2143. Each participating carrier shall conduct business with respect to health coverage which it cedes to the fund in the same manner as it would conduct business which it writes or administers without reinsurance from the fund. Health coverage which is ceded to the fund shall be only for services which are medically necessary, and the board shall require each carrier to strictly enforce the provisions of its small group health coverage contracts, including, but not limited to, all cost containment provisions.

2144. (a) The board shall provide for the proper funding of the fund including adequate, actuarially sound, but not excessive, reserves for unpaid losses, including incurred but not reported losses. Within 120 days following, and as of the end of, each calendar quarter the board shall determine, and advise carriers and the secretary, if there will be a deficit. A deficit shall exist if, in accordance with generally accepted accounting principles, the fund's liabilities exceed its assets.

(b) In the event that a determination is made that a deficit will exist, the board shall request the secretary, and the secretary shall assess all participating carriers an amount that is adequate to eliminate the deficit. The assessment shall be charged to participating carriers in proportion to and applied to their small group direct earned health premium and premium equivalence written in this state or, in the case of self-funded small group arrangements, paid claims plus administrative expenses. In no event shall total participating carrier

assessments exceed more than 5 percent of total small group premiums earned for the calendar year by all participating carriers.

(c) Upon a determination by the board that: (1) there is inadequate financial capacity among participating small group carriers to fund the program; (2) assessments against participating small group carriers exceed the limits set forth in subdivision (b); or (3) an assessment against a participating small group carrier results in an adverse impact on the carrier's large group rates, the board shall request the secretary, and the secretary shall assess each carrier which is not a small group carrier in proportion to and applied to its large group direct earned premium and premium equivalence written in this state. This second assessment shall not exceed 1 percent of the applicable premiums and premium equivalence.

(d) A carrier's assessment amount that is less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(e) If assets exceed liabilities in accordance with generally accepted accounting principles, the excess shall be held at interest and used by the board to offset future assessments of premiums.

(f) Each carrier's proportion of participation in the program shall be determined annually by the board based on annual statements and other reports filed by the carrier which are deemed necessary by the board.

(g) The board may defer, in whole or in part, the assessment of a carrier if, in the opinion of the board in consultation with the secretary, payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. In the event an assessment against a carrier is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessments set forth in subdivisions (b) and (c), provided such additional assessments not exceed the 5 percent total assessments permitted by subdivision (b), and the 1 percent total

assessments permitted by subdivision (c). The carrier receiving such deferment shall remain liable to the program for the deficiency.

2145. Any unsatisfied net liability or outstanding assessment owed by an insolvent carrier to the fund shall be assumed by and apportioned among the remaining carriers in the program in the same manner in which assessments are levied by the board pursuant to Section 2144. The board shall have all rights allowed by law on behalf of the remaining carriers against the insolvent carrier for sums due the program.

2146. (a) The program, and its officers, directors, agents, and employees shall under no circumstances be liable for any extra-contractual damages, including, but not limited to, punitive damages, and the cost of defending any lawsuit or claim for extra-contractual damages.

(b) Any person or carrier of the program made a party to any action, suit, or proceeding because the person or carrier served on the board of directors or on a committee, or was an officer or employee of the program, shall be held harmless and be indemnified by the program against all liability and costs, including the amounts of judgments, settlements, fines, or penalties, and expenses incurred in connection with the action, suit, or proceeding. However, the indemnification shall not be provided on any matter in which the person or carrier is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of the office.

Article 4. Large Group Purchasing Pools for Small Business

2150. (a) Effective July 1, 1993, small businesses shall be eligible to purchase basic health coverage through legitimate large group purchasing pools.

(b) No carrier shall refuse to sell coverage to a legitimate large group purchasing pool because of its

status.

(c) For purposes of this section, large group purchasing pools include the following:

(1) Nonprofit regional purchasing pools for small businesses organized and operated by the Public Employees' Retirement System.

(2) Any other multiple employer trust or any entity organized in whole or in part for the purposes of securing group health coverage at favorable negotiated rates which shall be subject to regulation by the Department of Insurance under such conditions as it finds necessary to prevent fraud, insolvency, unfair, deceptive, or selective marketing practices.

(d) Effective July 1, 1995, small businesses shall be eligible to purchase basic health coverage through a state organized purchasing pool with subsidies for small low wage employers and for startup small employers as set forth in Article 2 (commencing with Section 2100) of Chapter 5.

2151. All multiple employer trusts organized for the purposes of paying for writing, administering, reissuing, negotiating for, or otherwise providing health care coverage in the state shall be subject to regulation by the Department of Insurance under such conditions as the department finds necessary to prevent fraud, insolvency, unfair, deceptive or selective marketing practices.

2152. In accordance with Section 51 of the Civil Code, a carrier shall not arbitrarily discriminate against individuals in the setting of insurance rates or in the denial of insurance coverage.

2153. The Insurance Commissioner or Department of Corporations may disapprove the use of any advertising or solicitation which is untrue, misleading, or deceptive.

2154. The Insurance Commissioner or Department of Corporations shall not permit the use of any health insurance rating plan that discriminates on the basis of race, language, color, religion, ancestry, or national origin.

2155. The Insurance Commissioner or Department of Corporations may disapprove any marketing or

advertising plan or plan of selective enrollments or terminations which is determined to be a deceptive or unfair business practice or have the effect of defrauding the public.

2156. The Insurance Commissioner or Department of Corporations may disapprove the form and content of any contract for health insurance which are determined to be a deceptive or unfair business practice or have the effect of defrauding plan subscribers of medically necessary basic health services.

2157. Health insurers shall not exclude or otherwise limit any individual from group coverage under any plan of basic health care coverage on the basis that the individual has, or at any time has had, any disease, disorder, or condition.

2158. Health insurers shall enroll, not later than the first day of the calendar month following 30 days from the termination date of coverage, any individual who would otherwise be covered by a group coverage and whose duplicate coverage is terminated as set forth in subdivision (d) of Section 2034.

2159. To the extent they are offering to provide or are providing basic health care coverage, health insurers are exempt from any law mandating benefits or mandating the offering of benefits except as specifically provided in this article, but they shall be bound by all other provisions of their enabling or licensing statutes and by any other provision of the general laws applicable thereto.

2160. A health insurer may offer and provide health care coverage which exceeds the requirements established for basic health care coverage through a supplemental policy. Sections 2116 to 2159, inclusive, shall apply to the basic health care coverage portion of that coverage, but shall not apply to the supplemental policy providing coverage which exceeds that required for basic health care coverage.

2161. Any health insurer that violates this chapter shall be deemed to have committed a violation of its enabling or licensing statutes, subjecting it to all enforcement actions available to the Insurance

Commissioner or Commissioner of Corporations, as applicable.

CHAPTER 7. MISCELLANEOUS PROVISIONS

Article 1. Medical Standards Committee

2165. Any reference to the committee that appear in this article shall refer to the committee of the California Health Plan Commission created to make recommendations on medical standards pursuant to Section 2023.3.

2166. Within 60 days after the appointment of the commission, the medical standards committee shall convene its first meeting.

2168. The committee shall do all of the following:

(a) Recommend to the commission minimum utilization review standards for the utilization review programs of carriers providing basic health care coverage reasonably necessary to protect patients and health care providers from erroneous decisions, undue administrative burdens and costs and breaches of confidentiality.

(b) (1) Recommend to the commission those health care procedures, services, drugs, or devices which are experimental, investigational, outmoded, not efficacious, or otherwise not sufficiently cost-effective to be included in basic health care coverage.

(2) In making determinations pursuant to paragraph (1), the committee shall consider the opinions of the state and national medical and specialty organizations, the National Institutes of Health, and other interested parties.

(c) Analyze the utilization data collected by the commission for patterns of practice and report annually to the commission its recommendations for improving the quality and availability of care.

(d) (1) Contract with nonprofit professional medical, osteopathic, podiatric, hospital and health facility societies exempt from taxes pursuant to Section 23701 of

the Revenue and Taxation Code for peer review to evaluate aberrant patterns of practice of providers discovered in the course of the committee's duties set forth in subdivision (b) or brought to the attention of the commission by carriers.

(2) The names and license numbers of providers identified as engaging in aberrant practices shall be transmitted to the utilization review program of participating carriers, to be used for provider education and claims review.

(e) Review the practice parameters developed by state and national medical and specialty organizations, the National Institutes of Health, and other interested parties and recommend to the commission practice parameters for basic health care coverage.

(f) Advise the commission of its recommendations relating to the administration of this chapter.

(g) Hold hearings.

2169. The records and proceedings of the committee and the contracting organizations shall be confidential unless and until a licensing agency takes formal action.

2170. (a) The committee may establish subcommittees of its members it deems necessary to assist the committee in the performance of its duties, and may delegate the performance of its peer review duty set forth in subdivision (b) of Section 2168 to any subcommittee which has a minimum of two committee members.

(b) The committee may request the assistance of physician and surgeon members of a medical quality review committee established pursuant to Article 13 (commencing with Section 2320) of Chapter 5 of Division 2 of the Business and Professions Code, as it deems necessary to assist the committee or its subcommittees in the performance of its duties, and each committee member who agrees to serve shall be subject to applicable laws, rules, and regulations as if he or she were a member of the committee.

Article 2. Cost-Containment Committee

2180. It is the intent of the Legislature to provide fail-safe guarantees of affordability of the premiums for basic health care if they rise above an agreed-upon level.

2181. For purposes of this article, "committee" means the committee of the California Health Plan Commission created pursuant to Section 2023.1.

2182. Within 60 days of the appointment of the commission, the committee shall convene its first meeting.

2183. (a) The committee shall annually set an annual target for the increase in private health insurance premiums for the basic minimum health care coverage.

(b) The committee shall set the annual target after considering all of the following:

(1) The cost of delivering care.

(2) The capacity of purchasers to pay for care.

(3) Changes in technology.

(4) The changing demographic composition of the population covered.

(5) Opportunities for more cost-effective and efficient delivery of care.

(6) Changes in cost-shifting.

(7) Epidemics and natural disasters which seriously impact health care costs.

(c) No carrier shall increase premiums in an amount in excess of the target set by the committee except as authorized by the committee.

2184. The secretary shall report annually to the committee on the increase in carriers' premiums for the basic minimum services.

2185. (a) For any year following any year in which the total increase in private health insurance premiums for the basic minimum health care coverage exceed the target level, the committee shall limit carriers' premiums, hospital rates, and professional fees to limit the total increase in carrier premiums for basic health coverage within the target level.

(b) The committee may, when necessary, set limits on the increase in hospital rates and professional fees in a manner which limits the total increase for hospital and professional services within the target level, including adjustments for increases in utilization.

2186. (a) The committee may, upon determining it is necessary to maintain the solvency of a carrier, hospital, or other provider, exempt the carrier, hospital, or other provider from the limits established pursuant to this article.

(b) The committee shall, when making exemptions pursuant to subdivision (a), make any adjustments necessary to provide that the total increase in premiums and rates subject to this article do not exceed the total target level.

2187. No carrier shall increase premiums in an amount in excess of the target set by the committee except as authorized by the committee.

2188. Basic health care coverage through fee for service plans shall include provisions for cost sharing, provided the total annual cost sharing does not exceed 100 percent of the annual premium and no copayment or coinsurance exceeds 20 percent of the cost of a covered ambulatory or elective hospital service. No coinsurance shall apply to any nonelective hospital service as determined by the carrier. Deductibles shall not exceed two hundred fifty dollars ($250) annually for an individual or five hundred dollars ($500) annually for a family.

2189. The committee shall recommend cost-sharing provisions with reduced payments for persons below 200 percent of the federal poverty level.

Article 3. Capturing the Cost Shift

2200. (a) Effective July 1, 1996, acute care hospitals shall reduce their rates to reflect the elimination of the cost shift for bad debt and charity care to otherwise uninsured individuals who thereafter become insured.

(b) The extent of each hospital's rate reduction shall

be determined as follows: The amount of bad debt and charity care for 1994 as reported by the Office of Statewide Health Planning and Development and adjusted to cost, minus the amount of bad debt and charity care for 1995 as reported by the Office of Statewide Health Planning and Development and adjusted to cost, divided by the total revenues from all private carriers, multiplied by individual carrier revenues.

(c) Each private carrier shall reduce its premiums to individual and group purchasers in an amount equal to the dollar decrease in claims expenses due to this section.

(d) No rate or premium reductions shall occur unless and until there is an actual reduction in bad debt and charity care as reported in the data collected by the Office of Statewide Health Planning and Development.

(e) It is the intent of this section that actual reductions in hospital costs and expenses to care for the uninsured who are covered by the provisions of this bill shall be reflected in reduced premium costs to purchasers and payors of hospital services.

(f) The Department of Corporations and the Department of Insurance shall monitor carrier premiums to ensure this reduction is reflected in purchaser rates.

Article 4. Insurance Disclosure

2205. This article applies to group and individual disability insurance carriers, any nonprofit service plan, and any health care service plan.

2206. (a) An outline of coverage shall be delivered to a prospective applicant for basic health care coverage at the time of initial solicitation.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) The outline of coverage shall be a free standing

document and shall contain no material of an advertising nature.

(e) The outline of coverage shall, at a minimum, contain all of the following:

(1) An outline of basic benefits covered by the policy and exclusions from coverage.

(2) An outline of supplemental benefits covered by the policy.

(3) The basic rates for the basic health care coverage policy. For purposes of this section, "basic rate" shall mean the average composite per person per month rate for basic health care benefits under the policy.

(4) A description of rating practices and factors used under the policy to establish initial and renewal rates for basic health care coverage.

(5) The loss ratio for the policy for the prior calendar year.

(6) A description of the terms and conditions under which the policy may be canceled or nonrenewed.

(f) All elements of the outline of coverage must be presented in clear and plain English.

(g) Upon request, a prospective applicant shall be supplied with premium variations based on age, family size, occupation, geography, and supplemental benefits.

(h) The Commissioners of Insurance and Corporations shall issue regulations to implement this section.

2207. Not less than once per year and upon request each individual or group disability insurer, nonprofit hospital service plan, and health care service plan offering basic health care benefits coverage shall provide the Insurance Commissioner or Corporations Commissioner, as appropriate, in a format to be established by the Insurance Commissioner and Corporations Commissioner,, with information regarding the base rate for any basic health care coverage policy offered by the insurer or plan, a summary of variations from the base rate, and the loss ratio for the policy for the preceding 12-month period.

2208. At least once per year, the Commissioner of

Insurance or Corporations, as appropriate, shall publish and disseminate a comparison of premiums for basic health care coverage offered in the state including the base rate for each policy offered in the state and premium variations by age, family size, occupation, geography, and supplemental benefits, as well as loss and complaint ratios for each policy offered in the state.

2209. (a) It is unlawful for any individual or group disability insurer, nonprofit hospital service plan, or health care service plan to require, as a condition of purchase of a basic health coverage policy, the purchase of life, annuity, or disability benefits.

(b) Notwithstanding any other provision of law, an individual or group disability insurer, nonprofit hospital service plan, or health care service plan may offer a discount from the stated premium for basic health care coverage for the purchase of life, annuity, or disability benefits provided the premium for basic health care coverage is clearly and separately stated in the outline of coverage or offer of coverage.

SEC. 26. Section 17053.20 of the Revenue and Taxation Code is amended to read:

17053.20. (a) There shall be allowed as a credit against the amount of "net tax" (as defined in Section 17039) an amount equal to the amount determined in subdivision (b) for payments by an eligible employer to provide health coverage for eligible individuals and their dependents.

(b) The amount of the credit allowed by subdivision (a) shall be ~~twenty/five dollars ($25)~~ *forty dollars ($40)* per month per covered individuals or ~~25~~ *40* percent per month of the total amount paid or incurred for such health coverage by the employer during the taxable year, whichever is more, plus ~~twenty/five dollars ($25)~~ *forty dollars ($40)* per month or ~~25~~ *40* percent of the total amount paid or incurred per month per covered individual's dependent or dependents, whichever is more.

(c) To qualify for the credit provided in subdivision (b), an eligible employer must pay or incur at least 75

percent of the monthly premium for health coverage for eligible individuals who elect to have that coverage, or at least 75 percent per month towards health coverage for an eligible individual's dependent or dependents and for which the individual does not pay more than 25 percent, or both. At least annually, the employer shall make participation available to all eligible individuals and to all newly hired individuals within 60 days of the date of employment. Nothing in this section shall require an eligible employer to pay for dependent health coverage in order to qualify for the eligible individual health coverage credit provided herein. Nothing in this section shall prohibit employers from making additional health benefits available to an eligible individual at the employer's or eligible individual's expense. *The credit will be provided for no more than three years to any individual employer.*

(d) The credit allowed by this section shall be in lieu of any deduction to which the taxpayer otherwise may be entitled for expenses on which a credit under this section is claimed.

(e) ~~If the~~ *The* credit allowed under this section ~~exceeds~~ *may exceed* the "net tax" ~~for the taxable year, that portion of the credit which exceeds the "net tax" may be carried over to the "net tax" in succeeding taxable years until the credit is used. The credit shall be applied first to the earliest taxable years possible~~ *and any excess shall be refuned to the employer.*

(f) Any amount of expenses paid by an employer under this section shall not be included as income to the eligible individual for purposes of the Personal Income Tax Law. If those expenses have been included in arriving at federal adjusted gross income of the eligible individual, the amount included shall be subtracted in arriving at state adjusted gross income. As used in Section 17071 with respect to the eligible individual, "compensation for services" does not include expenses paid under this section.

(g) With the exception of a husband and wife, if two or more taxpayers share in the expenses eligible for the

credit provided by this section, each taxpayer shall be eligible to receive the tax credit in proportion to his or her respective share of the expenses paid or incurred. In the case of a partnership, the tax credit may be divided between the partners pursuant to a written partnership agreement in accordance with Chapter 10 (commencing with Section 17851), which includes Section 704 of the Internal Revenue Code concerning substantial economic effect, relating to partner's distributive share. In the case of a husband or wife who files a separate return, the credit may be taken by either or equally divided between them.

(h) For purposes of this section:

(1) "Eligible employer" means a taxpayer which employs on the average during the taxable year no more than 25 employees including owner-operators and which makes the minimum contribution required by this section on behalf of an eligible individual *and has not offered that contribution in the three tax years prior to the operative date of this section.* An "eligible employer" is not a taxpayer who liquidates the assets of or dissolves the organization of a business, for tax purposes only, in anticipation of becoming eligible for the credit allowed under this section and then subsequently reorganizes the business.

(2) "Eligible individual" means an individual who, on a form prescribed by the Franchise Tax Board and retained by the qualified employer, certifies that he or she is a resident of California (within the meaning of Section 17014), and who:

(A) Performs services for an eligible employer for an average of at least 35 hours per week for remuneration, or

(B) Performs services for an eligible employer for less than 35 hours per week for remuneration, if the eligible employer provides health coverage for that individual and meets all other requirements for the credit under this section, or

(C) As owner-operator or a managing partner, provides at least an average of 35 hours per week in

personal services to the business for which health coverage is contracted.

(3) "Health coverage" means health coverage that, at a minimum, includes basic health care services for illness or injury provided by a private insurance company holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health services under insurance policies or contracts, medical and hospital service agreements, membership contracts, in consideration of premiums or other periodic charges payable to it. "Health coverage" may include provisions for cost sharing if the total cost sharing does not exceed 200 percent of the annual premium, and no copayment exceeds 50 percent of the cost of a covered service.

(4) "Basic health care services" means the services defined in subdivision (b) of Section 1345 of the Health and Safety Code, or ~~those benefits and provisions as may be required of employers in this state by the enactment of Assembly Bill 350 of the 1989/90 Regular Session, or all of the following benefits:~~

~~(A) Inpatient and outpatient hospital services, including inpatient care for a period of at least 120 days of confinement in each calendar year and ancillary services.~~

~~(B) Inpatient and outpatient physician services.~~

~~(C) Diagnostic and screening tests.~~

~~(5) "Dependent" means any person who qualifies as a dependent of the eligible individual for purposes of a health care service plan certified to qualify for the credit allowed under this section.~~

~~(6) "Supplemental benefits" means:~~

~~(A) Prenatal and well/baby care which meets guidelines established by the American Academy of Pediatrics.~~

~~(B) Mental health benefits consisting of at least:~~

~~(i) Inpatient hospital care for a mental disorder for not less than 15 days per year.~~

~~(ii) Outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year.~~

~~(i) An eligible employer shall be entitled to an additional five dollar ($5) tax credit per month per covered employee for each of the two supplemental benefits~~ *pursuant to Article 1 (commencing with Section 2040) of Chapter 3 of Part 8.5 of Division 2 of the Labor Code.*

~~(j)~~

(i) The Department of Corporations shall forward to the Franchise Tax Board at least annually, or more frequently upon request, a list of all health care services plans licensed under Section 1353 of the Health and Safety Code which are required to provide the basic health care services defined in subdivision (b) of Section 1345 of the Health and Safety Code. The Department of Insurance shall forward to the Franchise Tax Board at least annually, or more frequently upon request, a list of all insurers authorized to transact disability insurance in this state and nonprofit hospital service plan corporations holding the certificate of authority required by Section 11504 of the Insurance Code.

~~(k)~~

(j) To be eligible for the credit under this section, each disability insurance policy, health care service plan contract, or nonprofit hospital service plan contract shall be certified as providing the basic health care services described in paragraph (4) of subdivision (h), and, if applicable, either or both of the supplemental benefits of paragraph (6) of subdivision (h), by legal opinion of the plan's counsel, a copy of which shall be provided to each eligible employer to be retained for submission to the Franchise Tax Board upon request. *The credit shall be provided for tax years beginning on or after January 1, 1993, and ending on or before December 31, 1995.*

~~(l)~~

(k) Subdivisions (a) to ~~(k)~~ *(j)*, inclusive, shall become

operative on ~~the date that the Tucker Health Insurance Act of 1989 becomes operative~~ *January 1, 1993.*

(l) It is the intent of the Legislature to adjust the tax credit for tax years beginning on January 1, 1995, and continuing thereafter so that half of the benefits of the credit accrue to small employers who provide basic health coverage and half are directed to the California Health Plan Fund.

SEC. 27. Section 23615 of the Revenue and Taxation Code is amended to read:

23615. (a) There shall be allowed as a credit against the tax (as defined by Section 23036), an amount equal to the amount determined in subdivision (b) for payments made by an eligible employer to provide health coverage for an eligible individual and that individual's dependent.

(b) The amount of the credit allowed by subdivision (a) shall be ~~twenty/five dollars ($25)~~ *forty dollars ($40)* per month per covered individual or ~~25~~ *40* percent of the total amount paid or incurred per month for such health coverage by the employer during the taxable year, whichever is more, plus ~~twenty/five dollars ($25)~~ *forty dollars ($40)* per month or ~~25~~ *40* percent of the total amount paid or incurred per month per covered individual's dependent or dependents, *whichever is more.*

(c) To qualify for the credit provided in subdivision (b), an eligible employer must pay or incur at least 75 percent of the monthly premium for health coverage for eligible individuals who elect to have that coverage and/or at least 75 percent per month towards health coverage for an eligible individual's dependent or dependents and for which the individual does not pay more than 25 percent. At least annually, the employer shall make participation available to all eligible individuals and to all newly hired individuals within 60 days of the date of employment. Nothing in this section shall require an eligible employer to pay for dependent health coverage in order to qualify for the eligible individual health coverage credit provided herein. Nothing in this section shall prohibit employers from

making additional health benefits available to an eligible individual at the employer's or eligible individual's expense.

(d) The credit allowed by this section shall be in lieu of any deduction to which the taxpayer otherwise may be entitled for expenses on which a credit under this section is claimed.

(e) If two or more taxpayers share in the expenses eligible for the credit provided by this section, each taxpayer shall be eligible to receive the tax credit in proportion to its respective share of the expenses paid or incurred.

(f) ~~If the~~ *The* credit allowed under this section ~~exceeds the taxes imposed by this part (except the minimum franchise tax and the alternative minimum tax) for the income year, that portion of the credit which exceeds those taxes may be carried over to the tax (as defined by Section 23036) in succeeding income years until the credit is used. The credit shall be applied first to the earliest income years possible~~ *may exceed the "net tax" and any excess shall be refunded to the employer.*

(g) Any amount of expenses paid by an employer under this section shall not be included as income to the eligible individual for purposes of the Personal Income Tax Law. If those expenses have been included in arriving at federal taxable income of the eligible individual, the amount included shall be subtracted in arriving at state taxable income. As used in Section 17071 with respect to the eligible individual, "compensation for services" does not include expenses paid under this section.

(h) For purposes of this section:

(1) "Eligible employer" means a taxpayer which employs on the average during the income year no more than 25 employees including owner-operators and which makes the minimum contribution required by this section on behalf of an eligible individual *and has not offered that contribution in the three tax years prior to the operative date of this section*. An "eligible employer" is not a taxpayer who liquidates the assets of or dissolves

the organization of a business, for tax purposes only, in anticipation of becoming eligible for the credit allowed under this section and then subsequently reorganizes the business.

(2) "Eligible individual" means an individual who, on a form prescribed by the Franchise Tax Board and retained by the qualified employer, certifies that he or she is a resident of California (within the meaning of Section 17014), and who:

(A) Performs services for an eligible employer for an average of at least 35 hours per week for remuneration, or

(B) Performs services for an eligible employer for less than 35 hours if the eligible employer provides health coverage for that individual and meets all other requirements for the credit under this section, or

(C) As an owner-operator or shareholder, provides at least an average of 35 hours per week in personal services to the business for which health coverage is contracted.

(3) "Health coverage" means health coverage that at a minimum, includes basic health care services for illness or injury provided by a private insurance company holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health services under insurance policies or contracts, medical or hospital service agreements, or membership contracts in consideration of premiums or other periodic charges payable to it. "Health coverage" may include provisions for cost sharing if the total cost sharing does not exceed 200 percent of the annual premium, and no copayment exceeds 50 percent of the cost of a covered service.

(4) "Basic health care services" means the services defined in subdivision (b) of Section 1345 of the Health and Safety Code, or ~~those benefits and provisions as may~~

~~be required of employers in this state by the enactment of Assembly Bill 350 of the 1989/90 Regular Session, or all of the following benefits:~~

~~(A) Inpatient and outpatient hospital services, including inpatient care for a period of at least 120 days of confinement in each calendar year and ancillary services.~~

~~(B) Inpatient and outpatient physician services.~~

~~(C) Diagnostic and screening tests.~~

~~(5) "Dependent" means any person who qualifies as a dependent of the eligible individual for purposes of a health care service plan certified to qualify for the credit allowed under this section.~~

~~(6) "Supplemental benefits" means:~~

~~(A) Prenatal and well/baby care which meets guidelines established by the American Academy of Pediatrics.~~

~~(B) Mental health benefits consisting of at least:~~

~~(i) Inpatient hospital care for a mental disorder for not less than 45 days per year.~~

~~(ii) Outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year.~~

~~(i) An eligible employer shall be entitled to an additional five dollar ($5) tax credit per month per covered employee for each of the two supplemental benefits~~ *Article 1 (commencing with Section 2040) of Chapter 3 of Part 8.5 of Division 2 of the Labor Code.*

~~(j)~~

(i) The Department of Corporations shall forward to the Franchise Tax Board at least annually, or more frequently upon request, a list of all health care services plans licensed under Section 1353 of the Health and Safety Code which are required to provide the basic health care services defined in subdivision (b) of Section 1345 of the Health and Safety Code. The Department of Insurance shall forward to the Franchise Tax Board at least annually, or more frequently upon request, a list of all insurers authorized to transact disability insurance in this state and nonprofit hospital service plan corporations holding the certificate of authority required by Section

11504 of the Insurance Code.

~~(k)~~

(j) To be eligible for the credit under this section, each disability insurance policy, health care service plan, or nonprofit hospital service plan contract shall be certified as providing the basic health care services described in paragraph (4) of subdivision (h), and, if applicable, either or both of the supplemental benefits of paragraph (6) of subdivision (h), by legal opinion of the plan's counsel, a copy of which shall be provided to each eligible employer to be retained for submission to the Franchise Tax Board upon request. *The credit shall be provided for tax years beginning on or after January 1, 1993, and ending on or before December 31, 1995.*

~~(l)~~

(k) Subdivisions (a) to ~~(k)~~ *(j)*, inclusive, shall become operative on ~~the date that the Tucker Health Insurance Act of 1989 becomes operative~~ *January 1, 1993.*

(l) It is the intent of the Legislature to adjust the tax credit for tax years beginning on January 1, 1995, and continuing thereafter so that half of the benefits of the credit accrue to small employers who provide basic health coverage and half are directed to the California Health Plan Fund.

SEC. 28. Section 9390.6 is added to the Welfare and Institutions Code, to read:

9390.6. (a) The department shall implement an expanded program of nursing home preadmission screening.

(b) The department shall do all of the following:

(1) Require nursing facilities to document that individuals considering admission are informed of the availability of other local home and community-based long-term care services for which the individual may be eligible.

(2) Expand preadmission screening of Medi-Cal recipients by Medi-Cal field offices or county social workers in the In-Home Supportive Services Program or the adult protective services program to include persons from the community who are considering nursing facility

placement, as well as those persons who are transferring from acute care hospitals.

SEC. 29. Section 14017.7 is added to the Welfare and Institutions Code, to read:

14017.7. (a) An aged, blind, or disabled individual, as defined in Section 12050, who is eligible for benefits under the federal Supplementary Security Income program pursuant to Subchapter XVI (commencing with Section 1381) of Title 42 of the United States Code or state supplementary payment benefits under Chapter 3 (commencing with Section 12000), and who receives a Medi-Cal card shall be provided by the department with a written notice informing him or her of eligibility for in-home supportive services, as provided pursuant to Article 7 (commencing with Section 12300) of this part, to the extent the recipient is not able to remain safely in his or her home without the provision of those services. The notice shall also inform the recipient that application for in-home supportive services may be made at the county welfare department.

(b) The notice required by subdivision (a) shall also inform the individual of the availability of other home and community-based services for which the individual may be eligible, including, but not limited to, adult day health care, the Multipurpose Senior Services Program, linkages, and senior nutrition programs, and direct the individual to contact his or her local senior information and referral agency.

(c) (1) County welfare departments shall provide any aged, blind, or disabled individual who is determined to be eligible for benefits under this chapter with a written notice informing him or her of eligibility for in-home supportive services, as provided pursuant to Article 7 (commencing with Section 12300), to the extent the recipient is not able to remain safely in his or her home without the provision of those services.

(2) The notice required by paragraph (1) shall also do all of the following:

(A) Inform the recipient that application for in-home supportive services may be made at the county welfare

department.

(B) Inform the individual of the availability of other home and community-based services for which the individual may be eligible, including, but not limited to, adult day health care services, the Multipurpose Senior Services Program, the Institutionalization Prevention Services Program (linkages) (Chapter 4.7 (commencing with Section 9390) of Part 1 of Division 8.5), and senior nutrition programs.

(C) Provide the telephone numbers for the locally available programs.

(D) Direct the individual to contact his or her local senior information and referral agency.

(c) The written notices described in subdivisions (a) and (b) shall also be provided by the department to each general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, and each long-term health care facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code, in this state for distribution to each aged, blind, or disabled individual, as defined in Section 12050, who is discharged from the hospital or facility into the community rather than to a general acute care hospital.

SEC. 30. Section 14595 is added to the Welfare and Institutions Code, to read:

14595. Notwithstanding any other provision of law, during the period that a risk-sharing contract is in effect, eligible providers shall be exempt from the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 fo the Health and Safety Code) regarding the services provided to Medi-Cal beneficiaries under the terms of the contract.

SEC. 32. Division 14 (commencing with Section 22000) is added to the Welfare and Institutions Code, to read:

DIVISION 14. CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

22000. The California Partnership for Long-Term Care Pilot Program is hereby established.

22001. The purpose of the pilot program is to link private long-term care insurance and health care service plan contracts which cover long-term care with the In-Home Supportive Services Program (Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9) and Medi-Cal, and to provide specified in-home supportive services benefits and specified Medi-Cal benefits to the purchasers of certified insurance policies and health care service plan contracts who exhaust the long-term care benefits of these insurance policies and health care service plan contracts.

22002. (a) The State Department of Health Services shall serve as the lead agency in administering this pilot program.

(b) The department shall seek any federal waivers and approvals necessary to accomplish the purposes of this division.

22003. (a) Individuals who participate in the pilot program and have resources above the eligibility levels for receipt of medical assistance under Title XIX of the Social Security Act (Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code) shall be eligible to receive those in-home supportive services benefits specified by the State Department of Social Services, and those Medi-Cal benefits specified by the State Department of Health Services, if, prior to becoming eligible for benefits, they have purchased a long-term care insurance policy or a health care service plan contract covering long-term care that has been certified by the State Department of Health Services pursuant to Section 22005.

(b) Individuals may purchase certified long-term care insurance policies or health care service plan contracts which cover long-term care services in amounts equal to the resources they wish to protect, so long as the amount of insurance purchased exceeds the minimum level set by the program.

(c) The resource protection provided by this division shall be effective only for long-term care policies, and health care service plan contracts which cover long-term

care services, that are delivered, issued for delivery, or renewed between July 1, 1991, and June 30, 1996, inclusive, or before the termination of the pilot program, whichever is sooner.

22004. Notwithstanding other provisions of law, the resources, to the extent described in subdivision (c), of an individual who purchases a certified long-term care insurance policy or health care service plan contract which covers long-term care services shall not be considered by:

(a) The State Department of Health Services in determining:

(1) Medi-Cal eligibility.

(2) The amount of any Medi-Cal payment.

(3) The amount of any subsequent recovery by the state of payments made for medical services.

(b) The State Department of Social Services in determining:

(1) Eligibility for in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3 of Division 9.

(2) The amount of any payment for in-home supportive services.

(c) The resources not to be considered as provided by this section shall be equal to, or in some proportion set by the department that is less than equal to, the amount of long-term care benefit payments made as described in Section 22006.

22005. The department shall only certify long-term care insurance policies and health care service plan contracts which cover long-term care that provide all of the following:

(a) Individual case management by a coordinating entity designated or approved by the department.

(b) The levels and durations of benefits which meet minimum standards set by the department.

(c) Protection against loss of benefits due to inflation.

(d) A recordkeeping system including an explanation of benefit report on insurance payments or benefits which count toward Medi-Cal resource exclusion.

(e) Approval of the insurance policy by the Department of Insurance as meeting the requirements of Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code, or approval of the health care service plan contract by the Department of Corporations pursuant to Chapter 2.2. (commencing with Section 1340) of Division 2 of the Health and Safety Code as providing substantially equivalent coverage to that required by Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code.

(f) Compliance with any other requirements imposed by the department through regulations consistent with the purposes of this division.

22006. The State Department of Health Services, in determining eligibility for Medi-Cal, and the State Department of Social Services, in determining eligibility for in-home supportive services, shall exclude resources up to, or equal to, the amount of benefit payments made by certified long-term care insurance policies or health care service plan contracts which cover long-term care services to the extent that the benefits paid are for:

(a) Those in-home supportive services benefits specified in regulations by the State Deparment of Social Services, and those Medi-Cal benefits specified in regulations by the State Department of Health Services pursuant to Section 22009.

(b) Services delivered to insured individuals in a community setting as part of an individual assessment and case management program provided by coordinating entities designated or approved by the departments.

(c) Services the insured individual receives after meeting the disability criteria for eligibiltiy for long-term care benefits established by the departments.

22007. The pilot program shall be designed so that the estimated aggregate state expenditures for long-term care services for individuals participating in the program do not exceed the aggregate expenditures that would be made for these services under the Medi-Cal program in effect prior to the implementation of this pilot program.

22008. Advice and counseling shall be provided to individuals interested in purchasing long-term care insurance or health care service plan contracts which cover long-term care services certified pursuant to this division. This counseling and advice may be provided by the Health Insurance Counseling and Advocacy Program within the Department of Aging, as well as by others.

22008.5. Upon the termination of the pilot program, individuals who participated in the pilot program shall remain eligible for those in-home supportive services benefits and those Medi-Cal benefits provided for by the pilot program for the life of the purchaser, as long as the purchaser maintains his or her insurance policy or health care service plan contract in force.

22009. (a) The State Department of Health Services shall adopt regulations to implement this division, including, but not limited to, regulations which establish:

(1) The population and age groups that are eligible to participate in the pilot program.

(2) The minimum level of long-term care insurance or long-term care coverage included in health care service plan contracts that must be purchased to meet the requirement of subdivision (b) of Section 22003.

(3) The amount and types of services that a long-term care insurance policy or health care service plan contract which includes long-term care services must cover to meet the requirements of Section 22005.

(4) Which coordinating entities are designated or approved to deliver individual assessment and case management services to individuals in a community setting as required by subdivision (b) of Section 22006.

(5) The disability criteria for eligibility for long-term care benefits as required by subdivision (c) of Section 22006.

(6) The specific eligibility requirements for receipt of the Medi-Cal benefits provided for by the pilot program, and those Medi-Cal benefits for which participants in the pilot program shall be eligible.

(b) The State Department of Social Services shall also adopt regulations to implement this division, including,

but not limited to, regulations which establish:

(1) The specific eligibility requirements for in-home supportive services benefits.

(2) Those in-home supportive services benefits for which participants in the pilot program shall be eligible.

(c) The State Department of Health Services and the State Department of Social Services shall also jointly adopt regulations which provide for the following:

(1) Continuation of benefits beyond the termination of the pilot program pursuant to Section 22008.5.

(2) The protection of a participant's resources pursuant to Section 22004, and the ratio of resources to long-term care benefit payments as described in subdivision (c) of Section 22004.

(d) The departments shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within 120 days of the enactment of this division to implement this division. The adoption of regulations pursuant to this section in order to implement this division shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section within 120 days of the enactment of this division shall not be subject to the review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (e) of Section 11346.1 of the Government Code.

22010. An executive and legislative advisory task force shall be formed to provide advice and assistance in designing and implementing the California Partnership for Long-Term Care Pilot Program.

(a) The task force shall be composed of representatives, designated by the chief officer or director of their agency or department, of:

(1) The State Department of Health Services.

(2) The State Department of Social Services.

(3) The Department of Aging.

(4) The Department of Insurance.

(5) The Department of Corporations.

(6) The Senate Office of Research.

(7) The Assembly Office of Research.

(b) The task force shall consult with persons knowledgeable of and concerned with long-term care, including, but not limited to:

(1) Consumers.

(2) Health care providers.

(3) Representatives of long-term care insurance companies and administrators of health care service plans which cover long-term care services.

(4) Providers of long-term care.

(5) Private employers.

(6) Academic specialists in long-term care and aging.

(7) Representatives of the public employees' and teachers' retirement systems.

22011. The State Director of Health Services shall annually report to the Legislature regarding the progress of the pilot program. The report shall be provided to the Legislature by January 1 of each year, commencing with 1992. The report shall include:

(a) The success in implementing the public and private partnership.

(b) The number and type of insurers and health care service plans with policies or contracts certified by the department.

(c) The number, age, and financial circumstances of participants in the pilot program who have purchased certified long-term care insurance policies and health care service plan contracts which cover long-term care services.

(d) The number of individuals seeking consumer information services and advice from the Department of

Aging pursuant to Section 22008.

(e) The number of participants actually receiving long-term care services, or the Medi-Cal and in-home supportive services benefits provided for by the program, and the type of benefits paid under certified policies and health care service plan contracts which cover long-term care that could count toward Medi-Cal resources protection.

(f) Estimates of the impact on present and future Medi-Cal expenditures.

(g) The cost effectiveness of the program.

(h) A recommendation regarding the continuation of the program.

22012. The State Department of Health Services, in conjunction with the State Department of Social Services, the Department of Aging, the Department of Insurance, and the Department of Corporations, shall submit an application for a grant to be used to pay the administrative expenses of implementation of the California Partnership for Long-Term Care. The department shall not implement this division unless a private grant is received to pay the administrative costs of this program.

22013. (a) In implementing this division, the State Department of Health Services may negotiate contracts, on a nonbid basis, with long-term care insurers, health care service plans, or both, for the provision of coverage for long-term care services that will meet the certification requirements set forth in Section 22005 and the other requirements of this division.

(b) In order to achieve maximum cost savings, the Legislature declares that an expedited process for issuing contracts pursuant to this division is necessary. Therefore, contracts entered into on a nonbid basis pursuant to this section shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 33. Not later than July 1, 1991, the State Department of Social Services and the State Department of Health Services shall submit, to the appropriate

committees of the Legislature, a joint report on both of the following:

(a) The feasibility of submitting a state plan amendment necessary to provide personal care services as a covered Medi-Cal service, including the provision of personal care services described in subdivision (f) of Section 440.170 of Title 42 of the Code of Federal Regulations.

(b) Whether the implementation of the amendment would require the expenditure of additional General Fund money.

SEC. 34. Prior to January 1, 1995, the Auditor General shall conduct an interim study to determine trends in health care insurance coverage and the impacts of voluntary insurance reforms. The study shall address trends and variations in coverage offered by employers, including variations by employer size, occupational grouping, location, wage level, demographic characteristics of employees and employment status.

SEC. 35. The Legislative Analyst's Office shall report to the Legislature, by March 1, 1991, on the projected revenues and costs of the provisions of this act.

SEC. 36. If any provision of this act is held by a court of competent jurisdiction to violate the federal Employment Retirement Income Security Act, this act shall be inoperative and have no effect. To that end, this act is not severable.

SEC. 37. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction or because funding will be provided in the annual Budget Act to cover any costs that may be incurred in carrying on any program and performing any service required to be carried on or performed by this act. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this

act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 38. Sections 4 to 24, inclusive, and Sections 26 to 32, inclusive, of this act, Chapter 1.5 (commencing with Section 2023) and Chapter 6 (commencing with Section 2115) of Part 8.5 of the Labor Code as added by Section 25 of this act, and Article 4 (commencing with Section 2205) of Chapter 7 of Part 8.5 of the Labor Code as added by Section 25 of this act, shall not become operative unless a constitutional amendment exempting the revenues provided for in Article 1 (commencing with Section 2050) of Chapter 4 of Part 8.5 of the Labor Code, as added by Section 25 of this act, from the appropriations limit set forth in Article XIII B of the California Constitution is enacted during the 1991–92 Regular Session of the Legislature and is approved by the voters, in which case these provisions shall become operative on January 1, 1993.

SEC. 39. Chapters 1 to 5, inclusive, and Articles 1 to 3, inclusive, of Chapter 7 of Part 8.5 of the Labor Code, as added by Section 25 of this act, shall not become operative, unless a constitutional amendment exempting the revenues provided for in Article 1 (commencing with Section 2050) of Chapter 4 of Part 8.5 of the Labor Code, as added by Section 25 of this act, from the appropriations limit set forth in Article XIII B of the California Constitution is enacted during the 1991–92 Regular Session of the Legislature and is approved by the voters, and then only if the finding required by Article 3 (commencing with Section 2045) of Chapter 3 of Part 8.5 of the Labor Code as added by Section 25 of this act results in that chapter becoming operative, in which case these provisions shall become operative on January 1, 1995.

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